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# CATASTROPHIC HEALTH INSURANCE

# HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDREDTH CONGRESS
FIRST SESSION

MARCH 26, 1987

Printed for the use of the Committee on Finance

Part 3 of 3

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# CATASTROPHIC HEALTH INSURANCE

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THURSDAY, MARCH 26, 1987

U.S. Senate,
Committee on Finance,
*Washington, DC.*

The committee met, pursuant to recess, at 10:05 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Lloyd Bentsen, chairman, presiding.

Present: Senators Bentsen, Baucus, Bradley, Mitchell, Daschle, Packwood, Roth, Chafee, Heinz, and Durenberger.

[The press release announcing the hearing and the prepared statements of Senators Baucus, Mitchell, Dole, Chafee, and Heinz follow:]

[Press Release No. H-25, March 6, 1987]

### Finance Committee to Continue Hearings on Catastrophic Health Insurance

Washington, DC.—Senator Lloyd Bentsen (D. Texas), Chairman, announced Friday that the Finance Committee will hold the next in a series of hearings to further consider the issue of catastrophic health insurance. This hearing will focus on the role of private insurance and on financing alternatives for catastrophic protection.

Chairman Bentsen stated that the Committee will explore the current role of private insurance, and how that role will be affected by various catastrophic proposals, including the effects on the current requirements pertaining to Medigap insurance, He further stated that the Committee will examine various alternatives for financing catastrophic coverage, including income-related options.

The hearing will begin at 10 A.M. on Thursday, March 26, 1987, in room SD-215 of the Dirksen Senate Office Building.

# STATEMENT BY
# SENATOR MAX BAUCUS
# SENATE COMMITTEE ON FINANCE
# HEARING ON
# CATASTROPHIC HEALTH INSURANCE
# MARCH 26, 1987

THE HEARING WILL COME TO ORDER.

GOOD MORNING.

TODAY'S HEARING IS THE THIRD IN A SERIES OF HEARINGS THAT THE FINANCE COMMITTEE HAS HELD ON THE SUBJECT OF CATASTROPHIC HEALTH INSURANCE.

SENATOR BENTSEN IS CURRENTLY MANAGING THE SENATE FLOOR DEBATE ON TWO IMPORTANT TRADE RESOLUTIONS. HE WILL JOIN US SHORTLY AFTER THE SENATE CONDUCTS TWO ROLLCALL VOTES ON THOSE RESOLUTIONS.

TODAY'S HEARING WILL EXAMINE TWO IMPORTANT ISSUES RELATED TO CATASTROPHIC HEALTH INSURANCE.

First, we will take a look at the role of private insurance coverage. We want to know how various catastrophic insurance proposals might affect private insurance plans, especially Medicare supplemental policies purchased by senior citizens. These are also known as "medigap" policies.

Before 1980, few states had any standards to protect the elderly from purchasing Medigap policies that did not provide a decent set of benefits at a reasonable price. Few laws or regulations existed to prevent flagrant misrepresentation of policies by high-pressure sales agents. And almost no information existed to help consumers make informed choices.

In 1980, Congress adopted model standards for the sale of Medicare supplemental plans based on legislation that I introduced in the Senate. Today, 46 states have laws and regulations that are at least as stringent as the minimum standards that Congress encouraged states to adopt seven years ago.

I AM AWARE THAT THE STANDARDS THAT WERE PUT IN PLACE WERE CONTROVERSIAL BACK IN 1980. SOME SAID THAT THEY WENT TOO FAR. OTHERS SAID THAT THEY REALLY WEREN'T TOUGH ENOUGH. THAT'S USUALLY AN INDICATION THAT A FEDERAL LAW IS SOMEWHERE IN THE RIGHT BALLPARK.

TODAY, WE NEED TO TAKE A HARD LOOK AT THOSE STANDARDS. WE NEED TO BE SURE THAT, PROTECTION FROM CATASTROPHIC FINANCIAL LOSSES DOES NOT LEAD TO CATASTROPHIC CONFUSION FOR THE ELDERLY. WE NEED TO FIND OUT WHICH STANDARDS THAT ARE ON THE BOOKS TODAY CAN BE STRENGTHENED AND WHICH ONES NEED TO ME MODIFIED.

IN SHORT, WE NEED TO KEEP THE INTERESTS OF THE CONSUMER CLEARLY IN MIND AS CONSIDER IMPORTANT AND NEEDED CHANGES IN HEALTH INSURANCE COVERAGE.

THAT ALSO LEADS US TO THE SECOND TOPIC OF TODAY'S HEARING: HOW TO FINANCE CATASTROPHIC INSURANCE BENEFITS.

WE WILL BE HEARING FROM SEVERAL WITNESSES WHO WILL PRESENT DIFFERENT OPTIONS ON HOW CATASTROPHIC

COVERAGE SHOULD BE FINANCED. THESE ARE VERY IMPORTANT ISSUES AND SOME OF THE TOUGHEST QUESTIONS THAT CONGRESS MUST ANSWER ABOUT CATASTROPHIC COVERAGE.

I LOOK FORWARD TO HEARING FROM OUR WITNESSES.

I REMIND ALL OF YOU WHO ARE TESTIFYING TODAY ABOUT THE COMMITTEE'S RULES ON LIMITING YOUR STATEMENT TO 5 MINUTES. WHEN YOU SEE THE RED LIGHT COME ON, I WILL BE ASKING YOU TO VERY QUICKLY FINISH YOUR STATEMENTS SO THAT WE HAVE THE OPPORTUNITY TO HEAR FROM ALL OF OUR WITNESSES.

# OPENING STATEMENT

OF

SENATOR GEORGE J. MITCHELL

FINANCE COMMITTEE HEARING

MARCH 26, 1987

CATASTROPHIC HEALTH CARE

We have heard in previous hearings before this committee on the subject of catastrophic health insurance, that well over 80% of the catastrophic health care expenses result from the need for long term care. In addition we have heard about the gaps in Medicare benefits for hospital and sub-acute, post hospital care. In a hearing before the health sub-committee of this committee, there was extensive testimony about other problems facing the Medicare system, relating to reimbursement, administration and eligibility.

Given the fact that the Medicare program was implemented over 20 years ago and has changed relatively little in that time, it is not surprising that there are a number of problems with the program. We clearly must attend to the gaps in acute care coverage. We must also begin to address, with the help of the private sector, the issue of benefits for long term care.

However simply adding benefits will result in another catastrophy in the near future-the rapid bankruptcy of the Medicare Trust Fund. I would remind you that it was only three years ago that we were told that we would face a negative fund balance as early as 1993. While the date is in question, we still face a major funding problem in the near future.

What we need to consider is a carefully planned, major restructuring of the Medicare system. We need to address not only the issues of benefits and financing, but the equally important considerations of eligibility, reimbursement, utilization and quality controls and program administration.

In any approach, we must stress equity in benefits as well as a responsible financing mechanism based on sound insurance principles. In addition we should forge a joint public-private effort to address the problem of long term care.

Such changes in the Medicare program are major and may be strongly opposed by those who favor gradual change or the status quo. However, without a blueprint for what we eventually want in the Medicare program, we risk building a pile of bricks rather than a house of which we can be proud.

The Medicare program is simply too important for us to wait until a crisis forces us act. To do so is to risk actions that may prove catastrophic to one of the most successful public policies we have.

## SENATOR BOB DOLE
## CATASTROPHIC HEALTH INSURANCE
## MARCH 26, 1987

I WANT TO THANK THE DISTINGUISHED CHAIRMAN OF THE SENATE FINANCE COMMITTEE FOR HOLDING THIS HEARING ON CATASTROPHIC HEALTH INSURANCE. I AM LOOKING FORWARD TO THIS OPPORTUNITY TO EXPLORE WITH THIS EXCEPTIONAL PANEL THE ROLE OF THE GOVERNMENT AND THE PRIVATE SECTOR IN FINANCING ALTERNATIVES FOR CATASTROPHIC PROTECTION.

### NEW BILL

ON MARCH 17, 1987 I WAS PLEASED TO INTRODUCE THE MEDICARE CATASTROPHIC ILLNESS AMENDMENTS ON BEHALF OF MYSELF AND MY DISTINGUISHED COLLEAGUES, SENATORS DANFORTH, DOMENICI, DURENBERGER AND CHAFEE.

THE ADMINISTRATION'S BILL WHICH I ALSO INTRODUCED REFLECTS MUCH OF THE WORK WE DID IN 1979, AS IN THE "3-D" BILL, AND WAS CERTAINLY A STEP IN THE RIGHT DIRECTION. THE BILL WE JUST INTRODUCED MODIFIES AND ADDS TO THIS PROPOSAL BY DEALING WITH SOME ADDITIONAL CONCERNS OF THE ELDERLY.

## FIRST STEP

AS MUCH OF THE TESTIMONY PRESENTED TODAY WILL POINT OUT, NONE OF THE BILLS INTRODUCED TO DATE ATTEMPT TO ADDRESS THE PROBLEM WITH THE FINANCING OF LONG-TERM CARE OR THE CATASTROPHIC NEEDS OF THOSE UNDER AGE 65. WHILE THERE IS NO LACK OF INTEREST IN THESE SUBJECTS, THE SOLUTIONS TO PROBLEMS ARE TOUGHER TO FIND - BUT REST ASSURED WE ARE SEEKING ALTERNATIVES.

THERE ARE SEVERAL KEY AREAS OF DIFFERENCE IN OUR BILL AND THE ADMINISTRATION'S. THE MOST OBVIOUS IS THE ONE TIME DEDUCTIBLE IN OUR BILL AS COMPARED WITH TWO IN THE ADMINISTRATION'S, IN ADDITION TO A LOWER CAP. OUR BILL ALSO HAS A HOLD HARMLESS CLAUSE SO SOCIAL SECURITY CHECKS WILL NOT DECREASE IN THE FUTURE BECAUSE OF THE PREMIUM BUT CLEARLY OUR EFFORTS ARE ONLY A FIRST STEP. MANY HAVE SUGGESTED ADDITIONAL AREAS OF SPECIAL CONCERN SUCH AS BALANCED BILLING AND DRUGS.

AS THE TESTIMONY TODAY PROCEEDS, I WOULD HOPE THAT WE COULD GET AN IDEA AS TO HOW WE CAN COORDINATE AN EFFORT TO PROVIDE WHAT THE ELDERLY NEED. IT IS UNCLEAR TO ME THAT ANYONE IS ADDRESSING THESE NEEDS IN AN AFFORDABLE MANNER. I AM INTERESTED IN METHODS TO FILL IDENTIFIED GAPS.

I AM ESPECIALLY INTERESTED IN THE TESTIMONY AS IT RELATES TO FINANCING. WE DON'T HAVE A SENSE OF HOW MUCH THE ELDERLY ARE WILLING OR ABLE TO PAY FOR COVERAGE. OUR BILL IS A PREMIUM BASED BILL, AS IS THE ADMINISTRATION'S HOWEVER, OTHER METHODS HAVE BEEN SUGGESTED THAT WOULD REFLECT, IN PART, AN INDIVIDUAL'S ABILITY TO PAY FOR SERVICES. IT IS IMPORTANT TO US TO HEAR HOW PEOPLE FEEL ABOUT THIS QUESTION.

## LONG-TERM CARE

WHAT WE DID NOT ADDRESS, NOR HAS ANYONE ELSE, IS THE ISSUE OF LONG-TERM CARE. THIS ISSUE IS SUBJECT OF GREAT INTEREST AND IS ACKNOWLEDGED BY ALL AS A SEVERE PROBLEM FOR THE ELDERLY. WHAT I DON'T HAVE IS AN ANSWER AS TO HOW TO FINANCE IT OR WHAT IN FACT WE WOULD PROVIDE. INCENTIVES THROUGH THE TAX CODE ARE CLEARLY AN OPTION, BUT MORE IMPORTANTLY WE NEED TO MAKE SURE THERE IS A PRODUCT OUT THERE TO PURCHASE. IT IS GOING TO BE IMPORTANT FOR US TO STRIKE A BALANCE WITHOUT SUPPLEMENTING APPROPRIATE PRIVATE CONTRIBUTIONS.

## CONCLUSION

WHILE THERE ARE NO EASY ANSWERS, THAT DOES NOT MEAN THERE ARE NO ANSWERS. IT IS CLEAR THAT THERE IS A MARKET FOR LONG-TERM

CARE IF WE LISTEN TO THE ELDERLY. WHAT IS NOT CLEAR IS THAT THERE IS A PRODUCT THAT SUPPLIES THAT MARKET. COVERAGE FOR THE UNINSURED AND THE UNINSURABLE IS ALSO NEEDED. IT BECOMES CLEAR THAT THERE MUST BE EXTENSIVE INTERACTION WITH THE PRIVATE SECTOR, INCLUDING THE PROVIDERS, AND THE BENEFICIARIES AS WELL AS THE GOVERNMENT. MY SENSE IS THAT ANY SOLUTION WILL HAVE TO BE CAREFULLY COORDINATED TO INSURE THAT ALL THE GAPS ARE FILLED. ONCE AGAIN, I WANT TO THANK THE CHAIRMAN FOR HOLDING THIS HEARING, AS IT IS CLEARLY AN ISSUE OF GREAT IMPORTANCE.

STATEMENT BY

SENATOR JOHN H. CHAFEE

AT

FINANCE COMMITTEE HEARING

ON

CATASTROPHIC HEALTH CARE EXPENSES

MARCH 26, 1987

Mr. Chairman, we can all agree on the benefits that should be included in a catastrophic health care package. We can agree that long term care is a critical issue for the elderly and that those under the age of 65 who have catastrophic expenses or who are uninsured should also be covered. However, the most difficult issue to resolve is how we can pay for these benefits. Today's hearing will focus on the issue of financing and I am looking forward to hearing the suggestions of the witnesses today.

In dealing with the financing issue I think we should be concerned about the ability of individuals on a fixed income to pay. By the same token, I think we must be cautious about proposals to increase the payroll tax or to assign an actuarial value to the Medicare benefit and include that value in taxable income. In short, Mr. Chairman, I am completely open to financing options and I hope that we will be able to resolve this issue in ~~a fair and~~ an equitable manner.

John Heinz

OPENING STATEMENT
BY
SENATOR JOHN HEINZ
COMMITTEE ON FINANCE
HEARING ON CATASTROPHIC HEALTH INSURANCE
THURSDAY, MARCH 26, 1987

MR. CHAIRMAN, I AM PLEASED THAT YOU HAVE CALLED THIS HEARING TODAY TO EXAMINE THE ROLE OF PRIVATE INSURANCE IN PROVIDING CATASTROPHIC HEALTH CARE COVERAGE.

PRIVATE INSURANCE COMPANIES HAVE PLAYED AN IMPORTANT ROLE IN SUPPLEMENTING MEDICARE COVERAGE IN THE PAST. TODAY, MORE THAN 70 PERCENT OF THE ELDERLY HAVE SOME FORM OF "MEDIGAP" INSURANCE TO SUPPLEMENT MEDICARE. IN 1984, THE INDUSTRY, WHICH CONSISTS OF BLUE CROSS/BLUE SHIELD AND MORE THAN 90 COMMERCIAL COMPANIES, REVEIVED NEARLY $4 BILLION IN PREMIUMS AND PAID OUT A LARGE PORTION OF THAT IN BENEFITS.

UNFORTUNATELY, THE POPULARITY OF MEDIGAP COVERAGE IS NOT NECESSARILY AN INDICATOR OF THE QUALITY OF THE PROTECTION. AN INDIVIDUAL WITH A MEDIGAP POLICY CAN STILL FACE SIGNIFICANT OUT-OF-POCKET EXPENSES. ACCORDING TO THE GAO, MOST PLANS PUT LIMITS ON COVERAGE FOR PART B COINSURANCE, USUALLY DO NOT COVER ANY COSTS THAT EXCEED MEDICARE'S APPROVED CHARGES AND DO NOT COVER LONG TERM CARE SERVICES. THE GAO ALSO FOUND THAT SOME POLICIES DO NOT COMPLY WITH THE REQUIREMENTS IMPOSED BY THE BAUCUS AMENDMENT, THAT IS THAT THEY PAY OUT IN BENEFITS AT LEAST 60 PERCENT OF THE PREMIUMS COLLECTED (75 PERCENT FOR GROUP POLICIES). THE RESULT IS EXCESSIVE PROFITS AT THE EXPENSE OF THE ELDERLY.

WHILE I SUPPORT A STRONG PRIVATE INSURANCE ROLE IN PROVIDING COVERAGE FOR THE ELDERLY, I AM DISAPPOINTED WITH THE PERFORMANCE OF SOME COMPANIES. OVER THE YEARS THERE HAVE BEEN WIDESPREAD REPORTS OF ABUSE IN THE MEDIGAP INDUSTRY, INCLUDING SCARE TACTICS, MISINFORMATION AND FALSE CLAIMS. THESE TACTICS CONTINUE TO BE A PROBLEM. ACCORDING TO A REPORT RECENTLY SENT TO CONGRESS BY THE SECRETARY OF HHS, AS MANY AS 40 PERCENT OF POLICY HOLDERS WERE SUBJECTED TO EXCESSIVE PRESSURE TO BUY A POLICY. THE SECRETARY ALSO FOUND THAT FEWER THAN HALF OF THOSE SURVEYED HAD MUCH KNOWLEDGE ABOUT WHAT THEIR POLICY COVERS.

NOW THAT WE ARE CONSIDERING LEGISLATION TO IMPROVE CATASTROPHIC COVERAGE FOR THE ELDERLY WE HAVE HEARD FROM REPRESENTATIVES OF THE INSURANCE INDUSTRY THAT THE GOVERNMENT SHOULD NOT GET INVOLVED. AT A HEARING OF THE AGING COMMITTEE IN JANUARY, MR. SHAPLAND, WHO WAS REPRESENTING THE HEALTH INSURANCE ASSOCIATION OF AMERICA, CLAIMED THAT "WE SEE NO COMPELLING NEED TO BEGIN A MAJOR OVERHAUL OF [MEDICARE]. IN OUR OPINION, THE CURRENT COMBINATION OF PRIVATE AND PUBLIC COVERAGE IS SERVING THE PUBLIC WELL."

I HOPE TODAY'S WITNESSES FROM THE INSURANCE INDUSTRY WILL NOT ARGUE THAT EVERYTHING IS O.K. WE IN THE AGING COMMITTEE AND ON THE FINANCE COMMITTEE HAVE HEARD TOO MUCH TESTIMONY FROM INDIVIDUALS AND THEIR REPRESENTATIVES ABOUT SERIOUS HEALTH CARE PROBLEMS TO BELIEVE THAT ALL IS WELL. INSTEAD, I HOPE WE WILL HEAR CONSTRUCTIVE SUGGESTIONS ON WAYS TO FINANCE CATASTROPHIC ACUTE AND TRANSITION CARE BENEFITS. AND, MORE IMPORTANTLY, WE NEED ASSISTANCE IN ADDRESSING THE REAL CATASTROPHE FACING THE ELDERLY -- THE ENOURMOUS BURDEN OF LONG TERM CARE.

THANK YOU, MR. CHAIRMAN. I LOOK FORWARD TO THE TESTIMONY.

Senator BAUCUS. The hearing will come to order.

Today's hearing is the third in the series that the Finance Committee has held on the subject of catastrophic health insurance. Senator Bentsen is presently on the floor managing two trade bills. The votes on those two bills will occur at 10:30 and at 10:45. Immediately following the conclusion of those two votes he will be back to chair the remainder of this hearing. In the meantime, we will proceed with the witnesses, so that we can get to the heart of the matter as quickly as possible, to make the best use of our time.

Today's hearing will examine two important aspects relating to catastrophic health insurance. First we will look at the role of private insurance coverage. We want to know how various catastrophic insurance proposals might affect private insurance plans, especially Medicare supplemental policies purchased by senior citizens, otherwise known as Medigap policies.

Before 1980, few states had any standards to protect the elderly from purchasing Medigap policies that did not provide a decent set of benefits at a reasonable price. Few laws or regulations existed to prevent the flagrant misrepresentations of policies by high-pressure sales agents, and almost no information existed to help consumers make informed choices.

Yet, back in 1980 the Congress adopted model standards for the sale of Medicare supplemental plans based on legislation that I introduced. Today, 36 states have laws and regulations that at least are as stringent as the minimum standards the Congress encouraged states to adopt seven years ago.

I was acutely aware back then that those standards were controversial. Some said they went too far, others said that they really didn't go far enough. In my experience, that is usually a pretty good indication that they are pretty much in the ballpark.

Today, however, we need to take a hard look at those standards. We need to be sure that protection from catastrophic financial losses does not lead to catastrophic confusion for the elderly. We need to find out which standards on the books today can be strengthened and which ones need to be modified. In short, we need to keep the interest of the consumer clearly in mind as we consider important immediate changes in health insurance coverage.

That leads to the second topic: How to finance catastrophic insurance benefits? We will be hearing from several witnesses who will present different options on how catastrophic coverage should be financed. These are some of the toughest questions that Congress must answer about catastrophic coverage.

I look forward to hearing from each of our witnesses. I remind the witnesses that we have a five-minute rule. We probably should encourage Senators to follow the same rule. But we have a five-minute rule for witnesses, at the very least, and I will tell each witness that when the five minutes are up a red light will go on here. That red light will indicate that I will probably encourage you, as diplomatically as I can, to quickly complete your testimony so we can get on to the next witness.

The first panel will include Mr. David Childers, Director of Insurance from the State of Arizona, and Mr. Earl Pomeroy, Commissioner of Insurance from North Dakota; James Moorefield, President of the Health Insurance Association of America; and fourth, Mary Nell Lehnhard, who is Vice President of Blue Cross and Blue Shield in Washington, D.C. So, will all four of you please come to the witness table?

Let us begin first with you, David. David Childers.

Mr. CHILDERS. Mr. Chairman, if you don't mind, we would like to begin with Mr. Pomeroy, because that is the way we have prepared our testimony.

Senator BAUCUS. All right. Mr. Pomeroy?

## STATEMENT OF EARL POMEROY, COMMISSIONER OF INSURANCE, STATE OF NORTH DAKOTA, BISMARCK, ND, ON BEHALF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Mr. POMEROY. Mr. Chairman, my name is Earl Pomeroy, Insurance Commissioner for the State of North Dakota. It is a pleasure to be with you this morning. I am Chairman of the National Association of Insurance Commissioners' State and Federal Health Insurance Legislative Policy Task Force. I am appearing this morning with Director David Childers, who is Chairman of the Accident and Health Committee of the National Association of Insurance Commissioners. These two NAIC committees, along with a third committee, the Medicare Supplement and Long-Term Care Insurance Task Force, chaired by Bill Gunter of Florida, are the NAIC committees primarily responsible for supervising and coordinating the regulation of Medicare supplement coverages.

The NAIC commends the efforts of the Fiftieth Congress and this committee in particular to provide for financing of catastrophic care for the senior citizens of this country.

As insurance regulators, Mr. Chairman, we believe these catastrophic care proposals impact our efforts at regulating the products put on the marketplace. Obviously, when we are talking about regulating coverages sold to cover what Medicare does not cover, any changes in the Medicare program changes the Medigap or Medicare supplement market. This in turn changes the regulation we must apply to this marketplace.

The NAIC is committed to updating its standards for the regulation of Medicare supplement coverages within 90 days after this Congress enacts into a law a change of the Medicare program to provide catastrophic coverages. Basically, Mr. Chairman, we see our role as state regulators as updating the Baucus requirements passed, as you mentioned in your overview, in 1980 to apply to the new Medicare supplement market.

During our testimony this morning we will also mention present regulatory activities being conducted by state departments on this market.

We have experienced a number of marketing complaints throughout the 50 States in the marketing of these coverages. I think that there would naturally be some activity which would come to the concern of regulators, given the fact that you have a very confusing type of product being sold, present Medicare supplement coverages, sold to a fragile and frail population that are subject to marketing practices which on occasion have constituted, frankly, consumer fraud.

The efforts of this Congress to simplify the Medicare program and put absolute stop-loss limits on an individual's exposure under what Medicare does not cover greatly simplifies the private marketplace in terms of covering that product which is not covered by Medicare. Therefore, we commend the legislation being considered.

The NAIC and the various state departments have undertaken a variety of public-education programs, so that the senior citizens are aware of what they are purchasing and aware of what to look out for.

I want to make it clear that there are a number of excellent Medicare supplement products on the market, and these products are being sold by a number of agents of very high integrity. So, it isn't entirely the bleak picture which I alluded to earlier.

Presently, there has been a lot of concern about mass marketing of Medicare supplement coverages, through television and direct response such as direct mail. There are presently three NAIC committees looking at what can be done to improve state regulation of these practices, if indeed they do constitute abuses.

A final area, Mr. Chairman, where the NAIC is examining, and that is, we are taking a look at actual loss ratio data and determining whether these policies are appropriately priced.

That concludes my remarks. Mr. Childers will briefly address what the NAIC is doing to regulate long-term care products.

Senator BAUCUS. Mr. Childers?

## STATEMENT OF S. DAVID CHILDERS, DIRECTOR OF INSURANCE, STATE OF ARIZONA, PHOENIX, AZ

Mr. CHILDERS. Thank you, Mr. Chairman. My name is David Childers. I am Director of Insurance for the State of Arizona, and I would like to restrict my comments primarily to the area of long-term care.

The states, Mr. Chairman, have evidence of a nationwide effort to foster the development of long-term care insurance. This effort is illustrated by the establishment of state legislative task forces and commissions which have reviewed a number of issues related to the financing and regulating of long-term care insurance. Many states are providing consumer education and counseling on Medicare, Medicaid, and private insurance policy benefits. This activity is accelerating, by the way, Mr. Chairman.

In 1986, legislation on long-term care insurance was implemented in 14 states. Some legislatures have directed their legislative research facilities to conduct studies on how to promote the development of private-sector long-term care insurance policies. Others have revised or established benefits standards or mandated long-term care coverage benefits.

In 1984, the increasing national concern over the financing of long-term care and the limited availability of insurance products to fulfill long-term care needs prompted the National Association of Insurance Commissioners to expand the charge of its existing Medicare Supplement and Other Limited Benefits Task Force to include those issues specifically. The task force was renamed as the Medicare Supplement Long-term and Other Limited Benefits Plans Task Force.

Because the current structure of long-term care financing is limited in part to public assistance programs, the NAIC recognizes the need for encouraging the private sector to become more involved in increasing the availability of long-term care insurance for the elderly. The demographic trend of increasing elderly population, the continued technological advances in medicine, and the tendency to limit state and federal spending on social programs are perceived as and they are, reasons for developing the availability of long-term care products within the private sector. Therefore, the Medicare Supplement Long-term and Other Limited Benefits Plans Task Force examined the feasibility of expanding the conventional coverage to include reimbursement for long-term care services, the collection of actuarial data to determine appropriate pricing of the product, alternative funding mechanisms for the product, and other legislative action which might encourage the marketing of the product and the identification of existing regulatory barriers through a more effective development of a private-sector product.

In late 1986, Mr. Chairman, a subgroup of the Task Force developed a Long-term Care Model Act. That Act ultimately was adopted by the entire NAIC. That Act is designed to promote the availability of long-term care insurance policies and to protect the public by setting certain standards governing the sale of such long-term care products. The model addresses performance and disclosure standards, cancellation terms, pre-existing condition limitations, prior institutionalization requirements, and the policyholder's right to return the policy—many of the same things that were addressed in Section 1882 of the Social Security Act.

Several state legislators are currently considering adoption of the NAIC Model Long-term Care Act. Among these are Arizona, Indiana, Iowa, Kansas—North Dakota has already adopted the law, and Virginia is considering it now. Several states have already enacted legislation similar to the NAIC Model Long-term Care Act, and a number of states last year enacted legislation which was in some regards even more aggressive than the Long-term Care Act.

In the way of summary, Mr. Chairman, NAIC was pleased to review the conclusory statement of the GAO report, and I quote section 1882, "when combined with state efforts, appears to be meeting its objectives of protecting the elderly against substandard Medigap policies and providing them with information on how to select Medigap policies."

Despite the generally favorable results of the GAO report, the NAIC agrees that effective regulation of Medicare supplement policy provisions and marketing practices requires persistent and diligent attention from state insurance regulators.

The NAIC offers its resources and energies as this committee addresses the catastrophic proposals and related issues of the sale of Medigap policies.

That concludes my formal statement, Mr. Chairman.

Senator Baucus. Thank you very much.

Next we have James Moorefield, President of the Health Insurance Association of America.

[Mr. Childers' and Mr. Pomeroy's written prepared testimony follows:]

# TESTIMONY
# OF THE
# NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

BEFORE THE
COMMITTEE ON FINANCE
OF THE
UNITED STATES
SENATE

MARCH 26, 1987

## Introduction

Mr. Chairman, I am Earl Pomeroy, Insurance Commissioner of the State of North Dakota and Chairman of the NAIC State and Federal Health Insurance Legislative Policy Task Force. I am appearing with David Childers, Director of Insurance for the State of Arizona and Chairman of the NAIC Accident and Health Insurance Committee. We represent the National Association of Insurance Commissioners, the association of the chief insurance regulators of the fifty states, the District of Columbia and the four United States territories. The issue before you today is the financing of catastrophic health care coverage.

As you know, many proposals are pending before this Congress, all of which seek to assist the elderly in covering expenses due to catastrophic illness. Although the proposals vary, they generally advocate the use of parts A and B of Medicare as a mechanism for providing catastrophic health care. The NAIC applauds this Committee for its efforts in addressing the crucial issue of the health care needs of the elderly. In response to Congressional inquiries, the NAIC has pledged to enact necessary amendments to the Medicare Supplement Model legislation within three months. We offer our assistance and that of the other state insurance regulators in achieving our mutual interests.

## Effect of Federal Catastrophic Legislation on NAIC Models

The passage of federal legislation increasing Medicare benefits for the elderly will necessitate amendments to the NAIC's model legislation on Medicare supplement minimum standards. The reason these changes will be required is that any increase in Medicare benefits will result in a decrease in Medicare supplement coverage. Therefore, the minimum standards in the NAIC models must be revised accordingly.

In response to the Baucus amendment, in 1980 the NAIC adopted a model statute and regulation, which have generally been enacted by the states in substantially similar form. The Medicare Supplement Insurance Minimum Standards Model Act establishes the states' authority to issue regulations establishing specific standards for the following: policy provisions, benefits, loss ratios, and disclosure provisions. The Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act is the vehicle which sets forth these standards. The model regulation will require certain revisions, depending on the federal catastrophic legislation which may be enacted. The states will, in turn, make the necessary adjustments to their legislation and/or regulations.

## Marketing of Medicare Supplement Policies

The NAIC shares this Committee's expressed concern regarding the marketing of medicare supplement policies to senior citizens. State insurance regulators approach unfair marketing practices through several methods. An initial significant step is to identify the abuses occurring in the marketplace. Seniors are encouraged to report insurance problems to the complaint divisions of their insurance departments through consumer guides, senior citizens forums and special elderly programs such as the Senior Health Insurance Benefit Advisors (SHIBA) in the state of Washington.

In an effort to enhance this educational effort the NAIC produced a public service announcement last year informing seniors of their insurance department's availability to answer questions. The Medicare Supplement Task Force is drafting a Health Program Guide for seniors which will be circulated nationwide. Additionally, the NAIC presently publishes in cooperation with the Health and Human Services (HHS) a Guide to Health Insurance for People with Medicare.

Effective consumer education will encourage seniors to contact the insurance departments with personal instances of stacking of duplicative coverage or misrepresentation in solicitation. Once complaints are received, the agent or company practices are investigated and enforcement actions are initiated as appropriate. Issuance of cease and desist orders, fines and suspension or revocation of agents' licenses are common enforcement responses.

In addition to marketing abuses as a result of agent activity, the NAIC is also concerned with direct mail and mass marketing advertising practices. The Medicare Supplement Task Force has as a top priority the issue of advertising directed to seniors.

Recently, the California Commissioner of Insurance required all health insurance carriers to submit their advertising files to the department for inspection and review to determine whether the advertising practices are in compliance with state law and regulations. This process of examining the marketing aspects of the health insurance field is supplemental to other methods of reviewing advertising practices of companies such as market conduct examinations. Other states, including Ohio, Washington and Minnesota, are requesting that insurers submit advertising for department review.

Another state is currently in the process of releasing a notice from its commissioner advising agents that certain practices in the use of "lead cards" may be in violation of the unfair trade practices act and the state's advertising regulations.

David Childers, Director of the Arizona Department of Insurance, recently issued a new guideline specifying filing procedures for advertising and sales solicitation material for health insurance. The guideline specifies that scripts must accompany tapes of television ads and that audio cassette tapes must accompany proposed radio ads. An explanation of intended usage must also accompany certain printed advertising and sales material.

## Loss Ratio Experience

The Baucus amendment established targeted loss ratios for medicare supplement policies. The targets are actually "expected" loss ratios, rather than ratios that must actually be met, of 60 percent for individual policies and 75 percent for group policies. Therefore, in order to satisfy the expected loss ratio, an insurer must demonstrate to the state that it anticipates paying out enough in benefits to meet the specified ratio.

According to the General Accounting Office (GAO) 1986 study on medigap insurance (Report to the Subcommittee on Health, House Committee on Ways and Means), the GAO and the HHS interpret Baucus to mean that states are not required to monitor loss ratio experience of medigap policies. Although not obligated to monitor this experience, several states have required insurers to submit information which would allow the computation of loss ratios. Loss ratios are calculated by dividing the amount of incurred claims by the amount of earned premiums for the reporting period.

In its study, the GAO obtained nationwide information from the states and computed cumulative loss ratios for 398 policies. A few of the policies exceeded the target ratios. Those policies that did not meet the target generally had less premium volume.

The NAIC's interest in satisfying the Baucus amendment is exhibited in its development of a Medicare Supplement Insurance Experience Exhibit which is now being submitted by companies with their annual financial statements. An exposure draft of a new reporting form is currently being considered by the Medicare Supplement, Long Term and Other Limited Benefit Plans Task Force. The new form is designed to collect data which will enable an evaluation of lifetime loss ratios as opposed to ratios over a limited period of time. This concept of viewing loss ratios over time, and consequently producing "mature" experience, was expressed to the GAO by several states. Therefore, the GAO report reflects this concern as well as the states' efforts to gather useful data which will enhance their ability to compute loss ratios.

The GAO report recognized the complexity of computing loss ratios as well as the disparity which may result in reporting combined loss ratios. A combined ratio may not necessarily reflect or promise any particular return to an individual. Rather, the combined ratio indicates only that policyholders as a group are receiving a fair return, according to the GAO report. Therefore, the NAIC concurs with the GAO's conclusion that it is important for policyholders to shop around in the selection of a medigap or medicare supplement policy to obtain the best possible return on the policy. To this end, the NAIC and the states are constantly reviewing their methods of assisting consumers in this regard.

## Monitoring of Long-Term Care Insurance

The states have evidenced a nationwide effort to foster the development of long-term care insurance. This effort is illustrated by the establishment of state legislative task forces and commissions which have reviewed a number of issues relating to the financing and regulating of long-term care. Many states are providing consumer education and counseling on medicare, medicaid, and private insurance policy benefits.

In 1986 legislation on long-term care insurance was implemented in 14 states. Some legislatures have directed their legislative research facilities to conduct studies on how to promote the development of long-term care policies. Others have revised or established benefit standards or have mandated long-term care coverage.

In 1984, the increasing national concern over the financing of long-term care and the limited availability of insurance products to fulfill long-term care needs prompted the NAIC to expand the charge of its existing Medicare Supplement and Other Limited Benefit Plans Task Force to include these issues. The Task Force was renamed as the Medicare Supplement, Long-Term and Other Limited Benefit Plans Task Force.

Because the current structure of long-term care financing is limited in large part to public assistance programs, the NAIC recognizes the need for encouraging the private sector to become involved in increasing the availability of long-term care insurance for the elderly. The demographic trend of an increasing elderly population, the continued technological advances in medicine, and the tendency to limit state and federal spending on social programs are perceived as reasons for developing the availability of long-term care products within the private sector. Therefore, the Medicare Supplement, Long Term and Other Limited Benefit Plans Task Force examined the feasibility of expanding conventional coverage to include reimbursement for long-term care services, the collecting of actuarial data to determine appropriate pricing of the product, alternative funding mechanisms for the product, and other legislative action which might encourage the marketing of the product and the identification of existing regulatory barriers to the development of long-term care coverage.

In late 1986, a subgroup of the task force developed a long-term care model act which is designed to promote the availability of long-term care insurance policies and to protect the public by setting certain standards governing the sale of long-term care policies. The model addresses performance and disclosure standards, cancellation terms, pre-existing condition limitations, prior institutionalization requirements, and the policyholder's right to return the policy.

Several state legislatures are currently considering adoption of the NAIC long-term care model. Among them are Arizona, Indiana, Iowa, Kansas, North Dakota and Virginia. Several states have already enacted legislation similar to the NAIC model on long-term care.

## Summary

The NAIC was pleased to review the conclusory statement of the GAO report that "Section 1882 [Baucus amendment], when combined with states efforts, appears to be meeting its objectives of protecting the elderly against substandard Medigap policies and providing them with information on how to select Medigap policies."

Despite the generally favorable results of the GAO report, the NAIC agrees that effective regulation of medicare supplement policy provisions and marketing practices requires persistent and diligent attention from the state insurance regulators. The NAIC offers its resources and energies as this Committee addresses the catastrophic proposals and related issues of the sale of Medigap policies.

## STATEMENT OF JAMES L. MOOREFIELD, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC

Mr. MOOREFIELD. Thank you, Mr. Chairman.

Gentlemen of the Committee, I am Jim Moorefield, President of the Health Insurance Association of America. At the March 10 hearing of the House Ways and Means Health Subcommittee, I made note of the fact that in about seven weeks I would be relinquishing my responsibilities as President of the Association to my successor. I am now down to five weeks. Also, on June 1, I have just been advised, I will be entering the rolls of the Medicare-eligible; so you see, sir, I have a special interest in this hearing and in the results that might flow from it.

Gentlemen, I had the pleasure of serving, along with Senator Durenberger, on Secretary Bowen's Public-Private Sector Advisory Committee on Catastrophic Illness. After hearing over 100 witnesses across the country, the Advisory Committee came to the unanimous conclusion that most Americans are adequately protected against catastrophic acute health care expenses through private insurance, or private insurance coupled with a number of public programs, but that the three most critical catastrophic illness problems to be addressed were: First, providing long-term care coverage, including convalescent and intermediate care in nursing homes and at-home care for the chronically ill; and second, providing basic as well as catastrophic coverage for the 35 million Americans who are without health insurance or whose health insurance is inadequate to protect against catastrophic illness—that is, the unemployed, the working poor, and the medical uninsurables; and then, third, for providing adequate coverage for the 3 to 5 million people over age 65 who do not qualify for Medicare and cannot afford private coverages.

The HIA compliments Secretary Bowen, compliments the President, the members of this committee and other members of Congress for bringing the problems of catastrophic illness to the public attention and in providing a forum like this in which we can discuss and advance viable solutions.

I appreciate the fiscal restraints that the Administration and the Congress are working under, but I would be less than honest if I didn't express my disappointment, sir, with the emphasis that is being placed on the need to first restructure Medicare—Medicare, a system that is working, and when coupled with provident insurance or with Medicaid is working extremely well.

I respectfully suggest that the present focus on Medicare restructuring is misdirected, and that the focus should be on the long-term care needs of the public and on providing adequate coverage for the uninsurables, the poor, and the near-poor.

I am proud of our industry's response to providing the coverage that Americans need, and especially in the Medigap business. Most Medigap policies being written today, sir, because of your good guidelines back in 1980, exceed your standards. Most of them provide benefits that are at least equal to or exceed of those benefits that Secretary Bowen and others are proposing. Just for a quick example:

We just completed a recent survey of 12 of the top commercial Medigap insurers, which represents about 66 percent of the Medigap business written by the commercial insurers. It shows that 86 percent of their policies cover unlimited hospital days, paying 100 percent of all Medicare-allowable hospital expenses, and that 93 percent of those policies provide unlimited coverage for Medicare-allowable Part B expenses.

Now, if you genetlemen feel that it is absolutely necessary to somehow assure more generous benefits than Medicare now provides, I suggest that you expand the Baucus minimum standards to include and assure a catastrophic feature, and that you enact legislation that will allow us, the private sector, to provide a freestanding affordable catastrophic product.

The Medicare, Medicaid and private health insurance system is working well for over 80 percent of the over-age-65 population. Of the remaining 20 percent, about half can afford but choose, for whatever reason, not to purchase supplemental insurance. You should concentrate on providing adequate coverage for the remaining 10 percent who do not qualify for Medicaid and cannot afford private coverage. The entire Medicare-Medigap system does not have to be restructured to meet the needs of that 10 percent of the over-age-65 population.

Mr. Chairman and gentlemen, the statement that you have in hand gives the HIAA position on how this may be resolved. I thank you for your attention. We stand ready to be of assistance whenever possible.

Thank you.

Senator BAUCUS. Thank you, Mr. Moorefield.

Next is Mary Nell Lehnhard.

[Mr. Moorefield's written prepared testimony follows:]

# Statement

of the

# HEALTH INSURANCE ASSOCIATION OF AMERICA

on

# PROPOSALS TO PROVIDE CATASTROPHIC COVERAGE UNDER MEDICARE

Presented by

James L. Moorefield
President

Before the

Committee on Finance
United States Senate

March 26, 1987

Washington, D.C.

I am James L. Moorefield, President of the Health Insurance Association of America. The HIAA is a trade association with a membership of about 335 insurance companies. Our members write about 60 percent of the health insurance available in this country.

The nature of our business has given the HIAA considerable experience in the field of health benefits over the last thirty years. We urge you to use this practical knowledge as you study the health care needs of people in this country.

To judge from news reports, the question of the hour is: Do Americans run the risk of financial ruin when faced with a catastrophic illness? In his report to the President last November, HHS Secretary Bowen said that the present health care system provides substantial benefits to most people. He noted that virtually all the elderly and nine out of ten people in the general population have health insurance. But he warned of gaps in catastrophic coverage that need to be filled, especially for older Americans and the working poor.

In the case of the elderly, some of these gaps have already been closed by a partnership between government and private insurers that protects older people from catastrophic hospital and medical bills. Medicare pays a large portion of the elderly's expenses for acute illness and private insurance policies known as "medigap" pick up the deductibles and coinsurance -- those gaps in coverage that Medicare assigns to the elderly to pay themselves. Today, seven out of ten older people have some form of private insurance or medigap to supplement their Medicare benefits thereby avoiding catastrophic hospital and medical bills.

A medigap policy allows older Americans to spend up to 150 days -- that's nearly five months -- in a hospital without paying any Medicare coinsurance. And, if an elderly patient exhausts his 150 day Medicare hospital benefits, but needs to remain in the hospital, his private medigap policy will cover another 365 days, paying at least 90 percent of all Medicare allowable hospital expenses.

In addition to covering hospital expenses, medigap policies help older people with some of their other medical expenses, particularly doctor's bills. Medicare pays 80 percent of these medical bills after determining the "reasonable and customary" charge for the services performed. Private medigap policies pick up the remaining 20 percent of expenses allowed by Medicare up to at least $5,000 a year.

Medigap policies are regulated by the states and must meed the standards I just described. These minimum standards were set by the Baucus Amendment to the 1980 Social Security Disability Act, an amendment designed to protect the elderly from overpriced or substandard medigap insurance policies. The standards set up by the Baucus amendment have been adopted in 46 of the 50 states, Puerto Rico and the District of Columbia.

In addition to enforcing minimum coverage standards for medigap policies, state laws also require insurers to pay benefits for pre-existing health conditions after the medigap policy has been in force for six months. Benefit payments must increase to keep up with rising health care costs along with changes in Medicare co-payments and deductibles. Older people are allowed to return the policy within 10 days for a full refund. Companies that sell Medigap insurance are also bound by fair trade practices such as simplified policy language and truth-in-advertising designed to protect the consumer.

I should also point out that current state law requires insurers to provide medigap consumers with simplified explanatory materials which describe what benefits Medicare and medigap policies do and do not cover. This Guide to Health Insurance for People with Medicare was developed by the National Association of Insurance Commissioners in coordination with the HIAA and the Health Care Financing Administration.

The conditions I have just mentioned are purely minimum standards that most medigap policies surpass. Many provide "first dollar" coverage by picking up the Medicare Part A hospital deductible (currently $520), as well as the Part B annual medical deductible of $75. A recent HIAA survey of 12 top commercial medigap carriers (representing about 66% of the total individual medigap business written by commercial insurers) shows that 86% of their policies covered unlimited hospital days, paying 100 percent of all Medicare allowable hospital expenses. The same survey showed that 93% of those companies' policies had unlimited coverage for Medicare allowable Part B expenses. Some medigap policies also cover expenses that Medicare will not pay for at all, such as dental and vision care, routine check-ups, hearing aids and out-patient drugs.

Last year, the GAO was asked to investigate the effectiveness of the Baucus Amendment in assuring the elderly that medigap policies meet their needs. The congressional watchdog agency reported its findings to the House Ways and Means Subcommittee on Health last October. In its review of 142 policies sold by 92 commercial insurers and 13 Blue Cross/Blue Shield plans, the GAO made no recommendations for further controls since, it said, the elderly were receiving adequate protection.

The GAO report also found that medigap policies sold by commercial companies with more than $50 million in premiums generally met the Baucus loss ratio requirements. That means that at least 60 cents of every premium dollar was returned as benefits or added to reserves. The loss ratios for the most commonly purchased policies, however, generally exceeded the recommendations found in the Baucus Amendment. For example, coverage sold by The Prudential Insurance Company for AARP members must by contract pay 80 cents of every dollar in benefits. Currently, about 10% of all Medicare beneficiaries have such coverage through the AARP. It is also important to point out that HIAA surveys show that nearly 40 percent of all medigap is purchased on a group basis. The Baucus Amendment requires all medigap sold on a group basis to pay at least 75 cents of every premium dollar in benefits.

The GAO report concludes that the protection these policies give the elderly could be considered a form of catastrophic health insurance. But the report also noted that few Medigap beneficiaries need this benefit since HCFA data shows that only about 2,000 Medicare beneficiaries, or .007 percent of people 65 and older, spent more than 150 days in the hospital in 1984.

It would seem then that older people who have bought medigap policies do not need to worry about catastrophic hospital expenses. They are, however, exposed to more serious financial consequences when faced with doctor bills since Medicare will only pay 80 percent of what it considers "reasonable and customary" medical charges. Even though medigap insurance picks up the remaining 20 percent of the Medicare allowance, older people are still responsible for paying the difference between what their insurance reimburses and what their physician charges.

Older people would be helped with this problem if the Health Care Financing Administration helped them identify those physicians and other providers who accept Medicare's fees as full payment for their services. HCFA could publish directories with the names and addresses of participating physicians and even provide toll-free hotlines. It could also develop incentives for electronic billing of physician claims as well as for streamlining the coordination of billing for Medicare and Medigap benefits.

We would also encourage Medicare to be more aggressive in its pursuit of cost containment. This means more stringent utilization review, pre-admission certification and mandatory second surgical opinion programs. These are all techniques used routinely in privately managed health care plans.

In spite of these problems, Medicare and private health insurance are protecting most of the nation's elderly from catastrophic acute care costs. In January 1987, the HIAA commissioned Market Facts, one of the largest marketing firms in the country, to assess consumer experience with medigap policies. Over 1,500 people 65 and older who have medigap policies were surveyed from a demographically balanced national sample. The survey found that 8 in 10 say they were not pressured into purchasing a medigap policy and an equal number say that their policy was fairly priced. Among those who have already filed a claim with their medigap insurer, 8 in 10 say that the claim was promptly paid and that the insurer paid as much of their medical costs as they expected. The survey also revealed that 9 in 10 of the people who filed a claim were satisfied with their policies. I have brought copies of a detailed report on this survey with me today which I will distribute to anyone interested in it.

Our research also indicates that Medicare and private health insurance are protecting about 70 percent of the nation's elderly from catastrophic acute care costs. Medicare and Medicaid cover another 10 percent, leaving 20 percent of those 65 and older vulnerable to the gaps in Medicare's hospital and medical benefits. About half of these people can afford private supplemental insurance, but have chosen not to purchase it. The remaining 10 percent of the elderly have no medigap insurance, but are not eligible for Medicaid. These are the elderly who need help most.

## INSURANCE INDUSTRY ALTERNATIVES TO MEDICARE CATASTROPHIC LEGISLATION: AMEND BAUCUS

### Including Catastrophic Features in Minimum Standards

The commercial health insurance industry believes that restructuring Medicare to cover catastrophic acute health expenses as proposed will provide limited benefits to few people, that most beneficiaries already have adequate private protection and that current proposals do not address true catastrophic expenses, such as long term care.

We feel that the private sector should be allowed to continue offering this protection. One way to assure that all Medigap meets Congress' new test for catastrophic acute medical expenses is to amend the Baucus law to make unlimited hospital and Part B coverage a minimum standard.

### Amending Baucus So That Insurers Can Offer a Catastrophic "Stand Alone" Plan

Congress should bear in mind before criticizing the industry regarding what it thinks is a failure to offer catastrophic coverage similar to the Bowen plan, that the 1980 Baucus standards are what Congress, the Administration, insurers, state insurance regulators, and consumers decided were necessary coverages when that legislation was being debated. Secretary Bowen simply has refocused the debate.

Insurers currently cannot write a stand-alone Bowen-type "catastrophic" policy and market it as a Medicare supplemental plan. This is because it would not match the Baucus minimum standards. Under current law some states would allow us to write such a limited benefit plan, so long as it is not called "Medigap." However, this could confuse consumers and thus limit such a plans' market appeal. If Baucus was amended so that insurers could underwrite a Bowen-type product and market it as a Medigap policy, this problem could be averted. Insurers feel that they can underwrite such a policy and sell it at a price comparable to Bowen's.

## MEDICARE CATASTROPHIC LEGISLATION: ACCOMMODATING EXISTING PRIVATE COVERAGE

### Waiver for Private Coverage

If a Medicare catastrophic restructuring plan is approved by Congress, such a bill might include a waiver provision so that if beneficiaries wish to be covered by a private Medigap plan rather than under new Medicare benefits, they may do so.

Many Medigap policies provide first dollar coverage and cover benefits that Medicare does not, such as physician balanced billing, vision and dental care, and prescription drugs. Allowing beneficiaries to choose this coverage to supplement current Medicare benefits, rather than rewriting Baucus, state laws, and private plans so that insurers can sell coverage to meet any gaps left over after a Medicare catastrophic plan is passed, would save months or years of confusion both among consumers and in the insurance marketplace. Also such a waiver would do nothing to prevent beneficiaries from choosing the government plan.

## Transition Rules

Finally, if a Medicare catastrophic plan is approved by Congress, adequate transition rules should be included allowing time for states to change existing laws regulating the Medigap business. At least an 18 month to 2 year period would be needed because some state legislatures meet only every other year.

If a Medicare catastrophic plan passes, it is likely that existing Medigap coverage would be considered duplicative. It is currently a violation of the Federal Baucus law to knowingly sell duplicative coverage unless the benefit payments are also duplicative. We are concerned that payments for claims would be made by both Medicare and private insurance. The negative cost containment factor upon both programs is real.

In addition, many private supplemental policies are "guaranteed renewable." This means that if new laws are passed affecting existing private coverage, insurers will be restricted from making changes in benefits that would dove-tail or supplement new Medicare benefits. The result would be additional and substantial consumer confusion over the relationship between private and governmental coverages.

Further, Baucus includes many consumer protections. For these reasons, the Baucus law will have to be amended and a transition period will have to be provided if the industry is to continue to cover any gaps in coverage which may remain after a Medicare restructuring law is passed.

## PRE-FUNDING RETIREE HEALTH BENEFITS

Another way to ensure that more Medicare beneficiaries have protection for gaps in coverage is to encourage more employers to provide health insurance benefits to their retired workers. The U.S. Department of Labor reports that currently only 57 percent of employees in large and medium-sized companies will receive employer-provided health benefits that supplement Medicare when they retire. Although this percentage is expected to grow, coinciding with the growing number of the elderly, the present federal tax policy is a major reason why many more employers are choosing not to do more for their retirees.

Specifically, the Deficit Reduction Act of 1984 has limited the tax advantage to pre-funding retiree health benefits. The HIAA urges Congress to consider the wisdom of a federal tax policy that discourages people from making financial arrangements today which would help pay for their health care tomorrow.

## LONG TERM CARE: THE REAL CATASTROPHE

Pre-funding for retiree health care would also help working people prepare for the biggest catastrophic health care cost of old age -- long-term care, the catastrophic expense that 90 percent of the elderly are unprotected from today.

A recent study, financed by the National Center for Health Service Research, determined that older people who had more than $2,000 worth of out-of-pocket expenses in a given year, spent 81 percent of this additional expense on nursing home care. At the same time, their annual out-of-pocket expenses for hospital and physicians fees were respectively 10 and 6 percent.

Most people do not realize the enormity of the risk they run when facing long-term care. In 1985, the insurance industry conducted a survey of 1,000

Americans between the ages of 50 and 64. Through it we learned that although more than half of them worry about a chronic illness or disability in their old age, less than one-fourth of them know that Medicare will be of little use to them should they ever need long-term care. Even more telling is the finding of a recent survey of the elderly by the AARP: about 80% believe Medicare covers long-term care.

Misconceptions about government assistance in paying for long-term care are echoed in popular beliefs about the role that private insurance plays in providing this kind of protection. In spite of industry educational campaigns, many older people still think that they already have long-term care coverage because they own a medigap policy. But medigap insurance is not long-term care insurance. Medicare's coverage of long-term care is limited and since medigap policies are designed to supplement Medicare, medigap long-term care benefits are also limited.

In an effort to eliminate these misconceptions, I personally offered the HIAA's assistance to HHS Secretary Bowen in embarking on two educational campaigns regarding the benefits and limitations of the Medicare program and the need for financial protection against expenses associated with long-term care. Our discussions have focused on targeting middle-aged sons and daughters of the elderly, as well as the elderly themselves. Although this effort is still in an exploratory stage, we feel the prospects for the campaign are promising.

The HIAA also has recently expanded existing educational programs regarding the need for long term care and defining what is and is not covered by Medicare and medigap. Following are some of our activities:

- Educational booklets for consumers, policymakers, and legislators.
- Op-ed and other advertising focusing on long-term care, Medicare and medigap (a medigap "Know Your Rights" ad has run in 50 Plus magazine and will soon run in newspapers in selected areas of the country.
- Consumer and agent-oriented slide shows.
- A consumer 800 number for information on the availability of long term care insurance in every state.
- Media seminars on long-term care.
- Long-term care kits for HIAA member companies designed to encourage development of new products.

Americans may not yet have accepted the idea that they need long-term care protection, but private long-term care insurance is available. In 1986 we surveyed our member companies and found that as of June 1986, 12 of them were offering individual long-term care policies of the indemnity-type. These are policies which offer a fixed amount of money per day. Since completing our survey we learned that four more member companies have entered the market. Today, an average of six HIAA companies are selling policies in each of the 50 states.

What is covered by the typical private long-term care policy? In our survey, we defined this type of policy as one which covers nursing home stays and/or home health care for not less than 12 consecutive months. The maximum benefit period for a typical policy, however, is 3 years, although a substantial number offer 5 years of coverage. This coverage appears to be adequate since one half of all nursing home residents stay only 90 days and 93 percent of all residents are discharged within 5 years.

Services covered in these policies include skilled, intermediate, custodial and home health care. Of the 12 policies analyzed in our survey, all offer skilled nursing care, 10 also provide intermediate nursing and custodial care, 8 include home health care, and 2 pay a cash benefit for purchasing necessary care at home.

We do not know how many long-term care policies have been sold because many companies have just entered the market. The companies that do have tallies, however, tell us that there were about 130,000 policyholders as of January 1986. Their average policyholder is 75 years old.

Another 15 HIAA companies are developing new long-term care products. Many of these are "group" policies which means they can be sold at a lower premium with little or no individual underwriting.

We believe that private long-term care insurance can play an important role in protecting many elderly from catastrophic long-term care costs. However, consumer education regarding the shortcomings of existing coverage is critical to the success of any long-term care financing scheme.

## CATASTROPHIC PROTECTION FOR THE UNDER 65 POPULATION

But what about the people who are under 65 years of age? For the working population, studies of group health insurance plans offered by employers show:

o 172 million individuals have major medical coverage providing hospital and medical benefits.

o Nearly 80% of working people today having maximum benefits of $1,000,000 or more (compared to 46 percent in 1980).

o 91% of all insured working people have limited out-of-pocket expenses of $2,000 or less (compared to 75 percent in 1980).

o Over 99% of all insured employees are covered for inpatient expenses associated with mental and nervous disorders.

o Over half of all insured employees have coverage for home health care and almost two thirds for second surgical opinions.

For the working poor, who earn less than $10,000 a year, but have no health insurance benefits, we suggest that Congress enact incentives to encourage small companies to cover their employees. Dr. Bowen proposed offering the self-employed full deductions on their own health insurance plans as long as they cover their employees as well.

We would also urge that state mandatory benefit laws be removed so that insurers can offer less expensive catastrophic-only health plans to small employers. States could also be given greater flexibility with Medicaid programs in order to cover the medically needy independent of other welfare programs and to cover low-income working parents, as well. It might also be possible to offer a subsidized Medicaid "buy-in" for uninsured low-income people who are not eligible for Medicaid.

We cannot fail to mention those who have no health insurance because they have chronic health problems such as diabetes, heart disease or AIDS that have made them ineligible for private individual insurance. Many of these individuals are working or can otherwise afford to buy coverage. The HIAA supports proposals to make health insurance available for those who find themselves in this situation. Last year, we supported legislation introduced during the 99th Congress by Senators Heinz and Durenberger, which would encourage states to establish risk pools for people considered uninsurable. We expect similar legislation to be introduced this year and we will continue to support these efforts.

Eleven states currently have some form of health insurance pool for uninsurables: Connecticut, Florida, Indiana, Iowa, Minnesota, Montana, Nebraska, North Dakota, Illinois, Tennessee, and Wisconsin. In 1975, the HIAA supported the creation of the first state risk pool in Connecticut. Because of this pool, there are now no uninsurables in Connecticut. Under the Connecticut law, the losses of the pool were to be shared among all the competitors in the health insurance market place -- the commercial insurers, Blue Cross/Blue Shield, HMO's, and self-insured employers -- on a pro-rata basis. Thus, the high-risk individuals received coverage but the competitive market place was not upset.

Subsequent court interpretation of the 1974 Employees Retirement Income Security Act (ERISA), however, which precludes the states from regulating employee benefit plans, means self-insured employers need not share in any pool losses. As more and more large employers self-insure, the burden of pool losses falls harder and harder on an ever decreasing base, principally small employers and individual purchasers of health insurance policies, who are already paying higher costs for their health protection. Federal legislation is required to solve this problem and to guarantee the establishment of a program in every state.

Most important, the state high risk pool would ensure the availability of health insurance for all Americans, regardless of health condition, with minimum federal regulation and at no cost to the federal treasury.

Finding ways to protect Americans from catastrophic health bills is complex because the elderly, workers, the poor and the uninsurables have different needs. Solving their problems will take time and ingenuity on the part of the legislators and insurers. But I think it is important to stress that our state and federal resources are limited. And what funds we have should be used to help the most vulnerable among us. Public money should not be spent to replace coverage adequately provided to the majority by the private sector.

Thank you, Chairman Bentsen, and members of the Committee for this opportunity to testify. The Health Insurance Association of America is willing to offer its assistance to this committee as you deliberate this pressing national issue.

## STATEMENT OF MARY NELL LEHNHARD, VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION, WASHINGTON, DC

Ms. LEHNHARD. Mr. Chairman, members of the committee, the Blue Cross and Blue Shield Association and its member plans are proud of the record that we have earned in more than two decades of providing quality supplemental benefits to nearly 10 million Americans. However, we believe that the needs of the low-income beneficiaries, those who really can't afford private insurance, are of such urgency that government action is needed.

If adding catastrophic benefits to Medicare will meet these needs, we will enthusiastically support this measure.

We also believe that the need for long-term care and the threat that it poses to both the financial security and the dignity of our older Americans remains the most significant problem facing both the elderly and their families. Thus, our statement covers both the issue of acute care catastrophic benefits under Medicare and the matter of long-term care, an issue which must be dealt with by both the government and the private sector.

Regarding acute care expenses, we believe that Blue Cross and Blue Shield Plan Medigap programs, which cover almost half of all beneficiaries who have supplemental protection, provide beneficiaries with substantial choice, good value, and comprehensive coverage. My written statement provides details on the costs, the benefits, and the value of our products.

However, the needs of the poor and the near-poor for comprehensive coverage for acute care expenses are not being met by private policies, neither are they being met by Medicare or Medicaid.

If you address this problem by expanding Medicare benefits, we would urge you to assure that the financing mechanism not burden those with low incomes. We urge you to explore options to achieve this important objective, such as income-related premium surcharges, or scaling the out-of-pocket expense limit to beneficiary income. We recommend that you not tax the part of the actuarial value of Medicare as a method of protecting the low income.

In implementing a new catastrophic program, we urge that a very special effort be made to address the beneficiary confusion that unavoidably is going to result. A major education program for beneficiaries, providers, and physicians will be necessary.

Regarding long-term care, private insurance can play a greater role, although the scope of that role is not yet clear. Government initiatives are needed to educate the elderly about the need for long-term care protection, to provide incentives for the private market to develop products, and to maintain and improve financing programs for persons, again, who won't be able to afford those private policies.

Protecting the elderly against the cost of long-term care—and I mean this both in terms of finances and human dignity—is a major challenge for the government and the private sector, and we very much look forward to working with you and helping you in any way we can as you tackle this difficult, complex, and extremely important issue.

Senator BAUCUS. Thank you very much, Ms. Lehnhard.

[Ms. Lehnhard's written prepared testimony follows:]

TESTIMONY
OF THE

BLUE CROSS AND BLUE SHIELD ASSOCIATION

ON
EXPANDING MEDICARE TO INCLUDE CATASTROPHIC COVERAGE

before the

COMMITTEE ON FINANCE

by

Mary Nell Lehnhard
Vice President

Thursday, March 26, 1987

March 26, 1987
Catastrophic Health Insurance

Mr. Chairman, I am Mary Nell Lehnhard, Vice President of the Blue Cross and Blue Shield Association. I appreciate this opportunity to testify on the issue of expanding Medicare to include catastrophic coverage. The Blue Cross and Blue Shield Association and its Member Plans have been major participants in the administration of Medicare since its beginning. Blue Cross and Blue Shield Plans also underwrite benefits to supplement Medicare coverage for about nine and one-half million beneficiaries, approximately 45 percent of all beneficiaries who purchase such coverage.

There is no question that the Medicare program, as presently designed, does not provide comprehensive protection against costs resulting from acute and chronic illness. For acute care, the Medicare program leaves beneficiaries liable for substantial deductibles and copayments on covered services, for medical fees in excess of the Medicare payment allowance on the one-third of claims that are unassigned, and for a wide range of non-covered services, such as out-patient prescription drugs.

For chronic or long term care, the Medicare program essentially provides no coverage. While this gap in coverage always has created the risk of hardship for Medicare beneficiaries, its adverse effects have been magnified as the incentives of the hospital prospective payment system have resulted in more frequent and earlier transfers of patients to nursing home and home care settings.

These benefit limitations do place beneficiaries at risk for financially catastrophic expenses. The need of the elderly for more comprehensive protection is clear.

## The Private Medigap Market

The private sector has taken steps to fill many of these needs. Most Medicare beneficiaries are protected against excessive out-of-pocket costs for acute hospital and physician care by private coverage which supplements Medicare benefits -- Medigap. Overall, 72 percent of the elderly supplement Medicare with private coverage, according to the Congressional Budget Office. About half of this supplemental coverage is provided on a group basis - mainly through retirees' former employers - and about half is purchased individually.

While there is wide variation in the costs, benefits, and availability of Medigap insurance products, we believe the private market has functioned reasonably well to protect the majority of the Medicare population from excessive financial liability for acute care. A 1980 amendment to the Social Security Act, often referred to as the Baucus Amendment, established minimum standards for state regulation and voluntary federal certification of Medigap policies. Forty-six states have adopted regulations meeting or exceeding the Baucus Amendment standards, thereby requiring that certified Medigap programs cover all Medicare hospital coinsurance. Approved programs also must cover at least 90 percent of the cost of at least 365 days of acute hospitalization after Medicare benefits have been exhausted. For Part B expenses, approved programs must cover at least $5,000 annually in Part B cost-sharing liability, once a $200 deductible is paid. The four remaining states have adopted their own standards that differ only slightly from those established by the Baucus provision.

Blue Cross and Blue Shield Plan Medicare supplemental programs provide consumers with value substantially in excess of the Baucus Amendment standards, as confirmed by the recent study of the U.S. General Accounting Office (GAO). The GAO study reviewed loss ratios from a sample of Blue Cross and Blue Shield Plan and commercial insurance policies, and concluded that the Blue Cross and Blue Shield Plan programs had a substantially higher aggregate loss ratio than did the commercial products.

Moreover, when we review all Blue Cross and Blue Shield Plans' Medigap products, we find loss ratios even higher than those calculated by GAO in its sample of Plans. The loss ratio measures the portion of the insurance premium that goes to pay benefits -- the higher the loss ratio, the greater the percentage of premium paid in benefits to or on behalf of subscribers. The Blue Cross and Blue Shield organization's aggregate 1979-1984 loss ratio on Medicare supplemental products was 90.8 percent, and many Plans incurred annual loss ratios exceeding 100 percent. Thus, we believe that Medigap products offered by Blue Cross and Blue Shield Plans provide good value to elderly consumers.

Blue Cross and Blue Shield Plan Medigap products offer substantial choices for coverage of acute care expenses that are neither covered by Medicare nor required under the Baucus Medigap standards. In 1985, for non-group products, we estimate that 88 percent of Plan products covered Part B expenses beyond the $5,000 minimum required under the Baucus Amendment, 84 percent of products covered each hospital deductible, 86 percent covered Skilled Nursing Facility copayments and 63 percent covered the $75 Part B deductible. In addition, 43 percent of Plan products included coverage for prescription drugs, 36 percent covered Skilled Nursing Facility days after expiration of Medicare benefits, and 29 percent included vision care coverage. We estimate that almost half of all Plans provide some protection against physicians' fees in excess of Medicare's allowed charge. This is usually accomplished by calculating the Medigap payment for Part B coinsurance using private UCR screens as a base. In some cases, Blue Cross and Blue Shield Plan programs also provide benefits such as wellness education, psychiatric benefits beyond Medicare, and convalescent homemaker services.

While comprehensive coverage is preferred by most Medigap buyers, many Blue Cross and Blue Shield Plans also offer less extensive and less costly coverage. This variety of coverage options is reflected in Plans' Medigap premiums, which ranged from $18.13 to $130.00 per month for non-group products in 1985. In that year, we estimate that 10 percent of all our non-group Medigap subscribers paid $20 or less per month, 40 percent paid $30 or less, and 75 percent paid under $43.

## Defining the Problem

While we believe that the Medigap programs offered by Blue Cross and Blue Shield Plans represent a "good buy" for most beneficiaries, there are those who cannot afford any private Medigap coverage. According to a study funded by the Health Care Financing Administration, about half of the beneficiaries without supplemental protection said they simply could not afford it.

This finding is confirmed by a Congressional Budget Office (CBO) analysis showing that low income beneficiaries are the ones most likely to lack supplemental coverage. According to CBO, nearly 30 percent of the elderly with incomes under $9,000 had no coverage in addition to Medicare, versus only 10 percent of those with incomes above $25,000. CBO also found that Medicaid fails to cover 72 percent of the elderly with incomes under $5,000. Thus, a major coverage gap left by Medicare, Medicaid, and private Medigap programs is the failure to provide adequate coverage of acute care expenses for the low income elderly.

The other major gap that is not presently being filled is the lack of catastrophic coverage for long term care.

Thus, in our view, the major problem of catastrophic health care for the elderly is twofold:

1) For acute care catastrophic expenses, the most significant problem is the affordability not the availability of adequate private health insurance, and,

2) For long term care, the problem is both one of affordability and availability. Medicaid requires individuals to become impoverished before becoming eligible for long term care coverage. Also, for a number of reasons, the private insurance market has moved cautiously in this area, representing only two percent of all spending for long term care.

In addressing proposed solutions to these problems, however, it is important to examine the role and responsibilities of the government and the private sector in assuring access to adequate health care coverage.

## Public and Private Sector Responsibilities

Our society has traditionally looked to government to help those who cannot provide for their own financial security or obtain financial access to health care coverage. Government also has an important role in assuring that consumers receive reasonable value in the market. This responsibility takes the form of assuring that beneficiaries are not victimized by improper sales techniques or by insurance that provides an unreasonably low value. The enactment of the Baucus amendment in 1980 after documentation of abuses was a significant step in fulfilling that responsibility. The GAO report confirms that the Baucus Amendment generally has been successful in achieving its objectives. Government also can play an important role in supplementing private sector efforts designed to assure that beneficiaries are well informed to shop effectively for private coverage.

In the context of catastrophic coverage for the elderly, we believe that the government has an obligation to help assure that low income persons who cannot now afford private coverage are adequately protected. The private sector, in our view, has a responsibility to develop innovative products that respond to consumer needs, to provide a fair value to the consumer, to educate consumers, and to help contain health care costs. We believe that the Blue Cross and Blue Shield organization's overall record in the Medigap market and our involvement in making capitated systems available to the elderly reflect our commitment to these responsibilities.

## Recommended Solution

Our recommended solution to the acute care catastrophic problem is to have the federal and state governments target their efforts to help the low income elderly, using general revenue financing to improve Medicaid coverage or to provide special financial assistance for the purchase of private coverage. Also, if further examination of the standards and consumer protections in current law shows them to be inadequate, they should be strengthened. Our Medicare supplemental products generally provide benefits and value far beyond the minimum requirements of the law, but we do not represent the whole market.

We recognize, however, that with the President's endorsement of Secretary Bowen's proposal and the widespread bipartisan Congressional support of the Secretary's general approach, the consensus view is not to spend additional federal money to solve this problem. The consensus approach is to incorporate this acute care catastrophic insurance protection in the Medicare program. We support this approach but urge that the design of the legislation consider carefully two fundamental aspects of the benefit -- financing for low income beneficiaries and beneficiary education. We would also urge that you consider carefully the future costs of these benefits and the effect of Medicare catastrophic coverage on alternative delivery systems such as HMOs and CMPs.

## Financing for Low Income Beneficiaries

Since we view the problem of inadequate catastrophic coverage for acute care expenses as one of affordability, we believe strongly that the financing mechanism should not place undue burdens on those with low incomes. Assuming that no federal funds would be used to subsidize the new benefits, this can be accomplished in one of two ways: (1) scaling down the benefits so that the premium to be paid by all beneficiaries is truly affordable to the low income, or (2) incorporating an ability-to-pay measure in the financing mechanism or in the design of the catastrophic benefits.

As a practical matter, the first approach is not feasible. We believe it would be extremely difficult to design a reasonable catastrophic benefit yet keep its average premium costs affordable to low income persons. For example, even if HHS's estimate of a $4.92 monthly premium for Secretary Bowen's program in 1987 was accurate, this amount would not be affordable to many lower-income beneficiaries. To illustrate this, we would note that beneficiaries entitled to the average Social Security monthly cash benefit received a 1987 cost of living adjustment of $6.00 per month. The new $4.92 monthly premium plus the 1987 increase of $2.20 in the regular Part B premium thus would wipe out the entire cost of living adjustment for the average beneficiary. This would reduce the real value of the cash benefit. Beneficiaries could face additional financial difficulties under the Administration's proposed increase in the basic Part B premium. Even if the basic Part B premium calculation were not changed, beneficiaries will face an estimated premium increase of $4.10 in 1988. By 1992, the Part B premium will increase to $26.00 under CBO's current law estimates.

Since it is not feasible to keep the average premium costs of the new benefits down to a level affordable to all beneficiaries, then the second approach -- incorporating an ability-to-pay measure into the financing or benefit design of the program -- should be considered.

With respect to specific approaches to incorporate ability-to-pay measures into Medicare, we recommend against taxing a portion of the actuarial value of Medicare benefit coverage. This approach would establish an open-ended liability for the taxpaying elderly to finance rapidly increasing Medicare costs and the cost of any new benefits. Moreover, since Medicare Part A is neither a cash benefit nor an "insurance" arrangement in the traditional sense, the rationale for such an approach appears questionable. Finally, taxing the actuarial value of Medicare could, by precedent, encourage increased taxes on employer paid health benefits for the general population. A reduction in tax incentives for employer paid coverage would only exacerbate the problem of covering the uninsured and underinsured.

As alternatives to taxing the actuarial value of Medicare, we urge you to consider:

1) An income-related premium set to finance the cost of catastrophic benefits only, added to the tax liability of beneficiaries who must file tax returns. For example, in addition to the regular Part B premium, beneficiaries in the 15 percent tax bracket might be required to pay as part of their tax filing an additional $100 premium to help finance Medicare catastrophic benefits; beneficiaries in the 28 percent bracket could be required to pay a higher amount. The precise thresholds and dollar figures to be used under this approach would need to be determined based on detailed cost estimates and policy considerations.

2) Tying the catastrophic benefits to ability-to-pay, financed by an affordable level premium paid by all beneficiaries. For example, this approach might involve a $2,000 cap on out-of-pocket liability for most beneficiaries but a higher cap for those who exceed the income threshold that triggers taxation of Social Security benefits. Again, the precise figures would be a matter for technical analysis and policy judgment.

## Beneficiary Education

An equally important issue is the need to minimize beneficiary confusion over the new program that is being considered. We know from our experience as Medicare contractors and as the major underwriter of Medigap coverage that beneficiaries now believe Medicare benefits are much richer than they actually are. We are concerned that a new federal catastrophic program could give many beneficiaries a false sense of security that could lead them to drop private coverage for the remaining acute care coverage gaps; discourage public interest in long term insurance; and reduce public understanding of the catastrophic spend-down requirements needed to obtain eligibility for Medicaid benefits.

The enactment of a new federal program also will result in activity in the marketplace and in the regulatory environment for Medicare supplemental insurance that may be confusing for beneficiaries. Many, if not most, of the minimum benefits for Medicare supplemental products adopted by states and encouraged by the 1980 Baucus amendment will be made superfluous by the inclusion of catastrophic benefits in Medicare. Thus, legislative and regulatory activity within the states will evolve over time to adapt to the new Medicare benefits.

We would be pleased to work with the Subcommittee, HHS, and state insurance commissioners on ways of minimizing beneficiary confusion over any new legislation providing catastrophic coverage.

## Future Costs of Catastrophic Benefits

As you consider specific proposals to include catastrophic coverage in Medicare, we would urge you to assess carefully the estimates of future year costs. The historical record of Medicare illustrates how difficult it is for anyone to predict accurately the cost of new benefits. A particularly difficult problem is predicting the behavioral response to the changes. With regard to catastrophic benefits, it will be important to assess the potential for inducing demand for services, particularly among beneficiaries not now covered by private Medigap programs. The importance in this area of accurate cost estimates is underscored by the difficult decisions that the Congress must make regarding the sources of financing for the new benefits.

## Effect on Alternative Delivery Systems

We also would urge you to consider the effects of Medicare catastrophic benefits on the capitated delivery system. To the extent that beneficiaries believe that the new benefits provide complete protection against the cost of acute illness, they may be disinterested in the comprehensive benefits offered by most HMOs and CMPs. This reinforces the need for beneficiary education. In addition, if it is determined that the introduction of the new benefits might seriously impede the growth of Medicare HMO enrollment, the Congress may wish to explore explicit incentives for joining HMOs.

## Other Elements of Medicare Catastrophic Coverage for Acute Care

We believe several other elements deserve consideration in any Medicare catastrophic coverage proposal. First, the elimination of the "spell-of-illness" concept in Medicare is long overdue. It has complicated program administration and is a constant source of confusion among the elderly.

Second, we support the use of an out-of-pocket limit on Part B expenses only. Given the design of Part A benefits, it is not necessary to link them to an out-of-pocket limit to assure catastrophic protection. Eliminating the spell-of-illness and providing 365 days of covered care, eliminating hospital coinsurance, and limiting the number of deductibles that can be incurred in any year effectively provides catastrophic protection for inpatient hospital services. A combined Part A and Part B out-of-pocket cap would also be more difficult and costly to administer.

Third, we recommend that the legislation or accompanying committee reports explicitly direct that the capitation payments paid to HMOs and CMPs participating in Medicare be adjusted upward to reflect the estimated costs of the new Medicare catastrophic benefits.

## Long Term Care

As we weigh the important public policy issue of how best to relieve the elderly of the fear of financially devastating health care expenses, we cannot overemphasize that the largest coverage gap is the lack of adequate long term care protection. As I mentioned earlier, the magnitude of this problem is increasing as the locus of health care shifts away from the acute care hospital setting. Thus, the major issue is how to improve public and private financing mechanisms for long term care.

Although the private insurance industry is beginning to respond to this need, we are not certain what portion of the long term care coverage gap can be filled by private initiatives. For example, meeting the long term care needs of those individuals who are already very old, have severe chronic illnesses, or have inadequate resources to devote to additional insurance will require a strong commitment of federal and state resources. Further, if we are to move away from the notion that the resources of the middle class should be decimated before Medicaid will help finance long term care, liberalizing Medicaid eligibility requirements must be considered. This, too, will require additional resources at the federal and state levels.

With respect to the long term care insurance, we recently completed an extensive examination of the potential market and the actuarial issues involved in developing sound products. We found substantial interest among consumers in long term care insurance. Based on our analysis, however, there are a number of uncertainties related to the funding of future year long term care expenses. As a result, Blue Cross and Blue Shield Plans will proceed carefully to develop and offer long term care insurance products.

One Blue Cross Plan entered the long term care insurance market in 1986. In addition, several other Plans are developing programs that they may introduce in 1987 on a pilot or broader basis. The experience to be gained by these efforts will be invaluable in determining more precisely what types of products best meet consumer needs and what data and techniques are most effective in establishing financially sound rate structures and in managing long term care benefit costs.

To facilitate private sector initiatives, we believe that government can play an important role in educating the public about the long term care gap in Medicare and the eligibility requirements for Medicaid coverage. Our own study showed that 54 percent of the elderly surveyed believed incorrectly that they already were covered for long term care. It also is appropriate to consider government incentives for the offering and purchase of long term care insurance. For example, one option that deserves careful consideration is permitting the tax-favored accumulation of long term care insurance reserves. Such a change would lower premium costs and provide an incentive for individuals to purchase coverage before they become elderly or need long term care services. It would also permit a greater portion of the interest earned on the reserves to be used to pay for long term care services. We would be pleased to work with the committee to explore this option further.

The complexity and magnitude of the long term care problem defies any easy solution. Moreover, we believe that it is both unrealistic and unproductive to frame this issue in terms of private versus public solutions. Addressing the long term care needs of the elderly will require and should as a matter of principle involve a combination of public and private sector initiatives. Solving this problem will require a major societal commitment of resources and creative energies to develop innovative solutions that preserve the dignity of our nation's elderly.

## Conclusion

I appreciate the opportunity to present our views on this important matter. But it is time to act and thus I wish to tell you where the Blue Cross and Blue Shield Association stands on the legislative initiatives you are considering.

While we are proud of our unmatched record gained in more than two decades of providing quality Medicare supplemental benefits to nearly 10 million of our citizens, we believe that the unmet needs of the low income elderly for protection against catastrophic medical expenses are of such urgency that government action is required.

If incorporating catastrophic benefits into Medicare meets these needs, we enthusiastically support such legislation.

We also believe that the threat to both the financial security and dignity of our older Americans posed by the need for long term care remains the most significant problem facing both the elderly and their families. Both public and private sector initiatives are needed to begin to solve this complex problem. We look forward to working with you on this important issue.

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Senator BAUCUS. A basic question I have is the panel's recommendations as to what we should do in response to the GAO finding that the loss ratios for smaller commercial insurers selling Medigap policies is below, generally, the 60-percent standard as provided in the legislation. In some cases for the smaller commercials, whose total premiums are $50 million or less, the loss ratios were 20 to 30 percent. What do we do about that? Let me first ask Mr. Childers and Mr. Pomeroy that question.

As you answer that question, I think it is important to keep in mind that generally the states only look at anticipated loss ratios but do not look at actual loss ratios. They generally do not take any subsequent enforcement action when the actual losses in fact are not the anticipated loss ratios. I would like the recommendations of both Mr. Childers and Mr. Pomeroy as to what we in the Congress should do about that.

Mr. CHILDERS. Mr. Chairman, with regard to target loss ratios, as you know, they are merely targets. The actuary that works for the Department of Insurance of the State of Arizona indicated to me that it is extremely difficult to forecast with a high degree of accuracy precisely what the loss ratio of a given product will be in the long term. So, I don't believe that the NAIC at this point has a position with regard to increasing or changing the loss ratio requirements.

However, I can tell you that the NAIC itself and a number of states are looking at that particular issue. The National Association of Insurance Commissioners is in the process now of accumulating long-term data on the target loss ratios to determine whether the companies are going to be able to meet these loss ratios or whether or not they are going to fall pitifully below them.

Senator BAUCUS. Do you have a personal view? You have a lot of personal experience here; what is your personal view on that?

Mr. CHILDERS. My personal view, Mr. Chairman, is that it wouldn't bother me to see the loss ratio requirements for individual policies boosted.

Senator BAUCUS. The loss ratio standards raised?

Mr. CHILDERS. Yes, sir.

Senator BAUCUS. For individual policies, what is a reasonable level?

Mr. CHILDERS. Well, that is a difficult question to answer without actuarial or technical back-up, Mr. Chairman. I think it would be irresponsible of me to guess what a good loss ratio would be.

Senator BAUCUS. But you think the present 60 percent is too low?

Mr. CHILDERS. I think it would be reasonable to consider increasing the present 60 percent.

Senator BAUCUS. Should there be additional incentives for states to look at actual loss ratios?

Mr. CHILDERS. Mr. Chairman, I think that is a very good idea. I believe that the states ought to take a more aggressive role in looking at actual ratios versus targeted ratios. But you must understand, and I think it is important for the committee to understand, that when a product is sold—and certainly industry representatives here can attest to this more effectively than can I—that it is very difficult to know, when you are developing a product, precisely what the loss ratio will be, and it probably would be unfair to, for example, suspend a company for not meeting loss ratio requirements in a given year or over a period of time if reasonable efforts were made to hit those targets.

Senator BAUCUS. What about that, Mr. Moorefield? The GAO found that over 60 percent of commercials' premiums of below 50 million had loss ratios below the standards, and in some cases 20 to 30 percent.

Mr. MOOREFIELD. Yes, among the 50 million, that is right, sir. For those that are over 50 million it was substantially higher than that. And you recognize, I know, that about 40 percent of the Medigap business is written through group insurance, and they have to have at least 75 percent or anticipate at least 75 percent.

Senator BAUCUS. But what about those poor folks that——

Mr. MOOREFIELD. But for the other ones, I can't explain why they were so low because I was not involved in the companies directly. I can give some observations, however.

During the period of the GAO study there were several factors taking place: One, DRG's were coming in, which sort of upset everything—how people were being paid, and what not. And one particular company, which is a large company and has more than 50 million but who was signaled for being on the low side, had a brand new policy that was included in it that had very limited experience.

I would agree with the Commissioner, you have got to have a longer period in which to assess that. I believe the Commissioners are preparing a report, if it is not already out, for the companies to report actual. So I think we have to look at that first, sir.

Mr. POMEROY. Mr. Chairman, if I might, you talk about looking at actual rather than anticipated. The Commissioners have moved to do just that, as Mr. Moorefield notes. We do require a statement now to be filed in connection with the annual statement which discloses actual loss history. Now, if in our analysis of their loss history it isn't hitting the 60-percent target area, we are going to go back and take a look at the rates which we have approved for the pricing of that product.

The thing that is important to note when you talk about mandating loss ratios is, you can immediately dry up the marketplace if you set a loss ratio so high that there no longer is room for the company to make any profit at marketing the product. I think that it is important that there be private insurance available, and so looking at marketing—looking at setting loss ratios has to be carefully done, looking at tracking actual loss history experience.

I can't say, based on the experience in North Dakota, that 60 percent is too low or too high; it actually requires much more in-depth analysis in terms of is there a product available. There certainly is at 60 percent. Has there been undue profiteering at that level? I cannot make that statement today, except that the point I want to leave with you is that Commissioners now are tracking actual loss ratios.

Senator BAUCUS. Thank you very much.

Under our early-bird rule, Senators asking questions in order will be Senator Daschle, Senator Durenberger, Senator Chafee, and Senator Heinz.

Senator Daschle?

Senator **Daschle**. Thank you, Mr. Chairman.

As the Chairman is, I am interested in this loss ratio question as well, and I am curious. There is obviously a very sympathetic view here of the problems associated with tying down the loss ratio too tightly on the insurance companies, but obviously in looking at some of these, the loss ratios are down to 30 percent in one case, and 24 percent. That is really abhorrent, really. I mean, what about the insurance holder who holds a policy with that company? Obviously you can't set a certain definitive loss ratio as acceptable in all cases, but what would you do with a company which is consistently found to be far short of the mark when it comes to an acceptable loss ratio? I would ask that of any one of the panel members.

Mr. **Pomeroy**. Senator Daschle, what I would do is immediately begin proceedings to rescind approval of the premium rates whereby that company is marketing that policy. Their rates are clearly too high for the benefits they are affording. And now that we are tracking the actual loss ratio experience, I think we will be able to do that. It is very important that we indicate to companies that there is effective state regulation that will force them to be hitting that 60-percent target level to the best of their ability.

Mr. **Moorefield**. Senator, if I could comment?

Senator **Daschle**. Yes.

Mr. **Moorefield**. I was with a company for 27 years. We were not in the Medigap business, but we were in the disability business, the individual disability business, and I can recall well—I was in charge of product development, and we came out with a new policy which we thought was going to be the hottest thing on the street. We thought it was properly priced. We didn't sell it. We had no claims under it, and we were so embarrassed that we voluntarily withdrew it from the marketplace, because we could not meet the anticipated ratios, which for the noncancellable type of policy was 55 percent.

Senator **Daschle**. Do you think there is a greater perception of the need to find some continuity in loss ratios now than there was a couple of years ago? A greater need to find some continuity? I mean, you are going from 84 percent down to as low as 30 percent I see on this sheet, and I was told 24 percent. That is quite a disparity in an industry offering virtually the same product. How can we ensure that, regardless of what the threshold be, there be greater continuity in loss ratios?

Mr. **Moorefield**. Again, I would just have to suggest, sir, that you have to look at that policy and how much experience they do have under it. Is it a new form? Was it one of those that was selected, one of the 93 policies that was selected, that has only been on the street for a six-month period or a year period? You have to look over the longer period for the actual loss ratio to be a judge of it, sir.

Mr. **Pomeroy**. Senator, there are some difficulties a company faces. There is a small North Dakota domestic company that is in trouble because it marketed a Medicare supplement product that is guaranteed renewable. They did not underwrite carefully, they assumed a great number of bad risks, and they are paying through the nose. Now, their premium may be even higher than the market, but their loss ratio is over 100 percent due to the underwriting and getting locked in on a guaranteed renewable contract.

There are a number of these marketplace considerations, and maybe one of the reasons the smaller companies had the lower loss ratios is that they were more conservative in pricing the product, and that would be because they don't have the margin of error. I mean, they miss, like the North Dakota company missed, and it threatens the life of the company. That may be part of the reason.

But that is not to say that regulators don't have an ongoing role of making sure they are hitting 60 percent.

Senator DASCHLE. I am new to the committee and new to this issue, by and large, and this may be a question that you have answered hundreds of times, but how would you describe for a novice in this area the difference that exists between Medicare's loss ratio and the industry's loss ratio? Medicare, as I understand it, is 97 percent, and the industry has set as a target 60 percent; but you have figures that are as low as 30 percent. Why the major disparity between Medicare and the private sector?

Mr. MOOREFIELD. Senator Daschle, if I might answer that, I would suspect that the primary difference would be that the Medicare program is not in the business to make a profit. So it may very well be that certain overheads, including taxes for example, would not be included as far as the expenses associated with the Medicare program, so they could operate at a higher loss ratio.

Senator DASCHLE. So you are saying taxes is the biggest difference between the two?

Mr. MOOREFIELD. Well, certainly taxes. Overhead may or may not be included in the case of the Medicare loss ratio; I don't know. Commissions paid to agents, and profits, anticipated profits by the company selling the product would.

Senator DASCHLE. Wouldn't you argue, if that is the case, that just solely from the philosophical point of view of the person paying the taxes, that it would be beneficial for that person to be in a national system, whereby the profits and taxes and large overhead is eliminated, and their loss ratio is 97 rather than 30 percent?

Mr. CHILDERS. Senator Daschle, that is a public policy issue as to how you want to distribute the cost of the given program, whether or not it should be borne by all the recipients or by the recipients who desire certain special benefits.

Senator DASCHLE. Thank you, Mr. Chairman.

Senator BAUCUS. Thank you, Senator.

Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, I would like to focus just a minute on what we are doing here.

Last week at a reach-out session we had in Minnesota, a woman came to talk about catastrophic insurance, and she described the case of her father who was paralyzed when he was 60 years of age. He couldn't speak. It was practically a total paralysis. He had spent 3 months in a hospital and went into a nursing home for 22 years and 6 months before he died. They depleted the entire family's assets—whatever they had were gone. The children chipped in everything they absolutely could, and finally the parents went on Medicaid.

Now, this woman will do anything, and so will that family, to get catastrophic insurance. They will buy anything. And I think what we are dealing with here is, what kind of choices do these people have?

In normal working life, a lot of times we have the choice of catastrophic insurance, but we don't take it, because we want to take the accident that might occur, the filling our teeth that we know is going to occur, all the immediate stuff. So, we put the catastrophic off at the time we could afford it most, and I think that you all understand that that is what we do.

Then when we get in the position where we don't have an income, we really need that catastrophic protection, it isn't there in the insurance plan that is handed to us by society—meaning the Medicare plan. We are handed one policy for free, in effect, the hospital policy, and then a second one which we pay something out of Social Security for, and I think 97 percent of the people buy into the second one. But in neither one of them is that one protection that those people feel they need the most, which is that financial catastrophy that will take away their home, take away their assets, take away their children's assets, their whole support system.

So the argument for catastrophic and the argument for restructuring this program is simply an argument made to us by our constituents, to give them a choice that today is much too complicated—much too complicated.

And I will grant you, Jim, that there is a lot of insurance out there. There are a lot of alternatives. All of us want to go to the private market.

But I have dealt now for 15 years with my mom and dad, at age now 75 and 80. Let me tell you, it isn't an easy deal for them.

So I think those of us who argue for acute-care catastrophic are not saying that there isn't an insurance market out there—there is. And I don't want to go into the GAO study with you; but, when you get down to 35 percent or 40 percent or 45 percent, which for some of those companies is all they are paying out for the money they are taking away from my parents—you know, don't blame that one on the DRG's. Blame that on the system that is very hard, I think, for insurance commissioners to regulate.

But the point here isn't to beat up on insurance companies.

Senator CHAFEE. Mr. Chairman, could I interrupt briefly here, while you are not beating up on insurance companies? [Laughter.]

And put in a statement for the record. I have to go over and vote.

Senator BAUCUS. It will be included.

Senator DURENBERGER. I just want to get to the point of whether or not, on the issue of restructuring this benefit, there is an argument that is made from the insurance industry that we shouldn't build catastrophic into the Medicare system, because it exists out there in the private market.

Jim, is that the argument that the health insurance industry is making?

Mr. MOOREFIELD. I wouldn't argue that point with you, sir, because I think there is a different point that has to be made. What is being proposed thus far in the way of catastrophic adds no new benefit. It wouldn't have taken care of your friend's father paralyzed in the nursing home for 22 years. Their are ways that could have taken care of that. The Blues have an open enrollment period. Our own, under Medigap, under the Baucus Amendments, we have a six-month elimination period; so, that family would have had to pay that nursing home for 6 months.

But if you will look at the major companies today, mail-order or direct, AARP cases, they are taking people without medical examination.

I put the question to a group of Medigap writers just this week: My wife unfortunately now has cancer. She is now of age for Medicare, but I said, "Look, you are talking about you have sold these policies. Would you accept her as a risk?" Every company there said, "Yes, subject to the elimination period of 6 months."

Senator BAUCUS. Gentlemen, I am going to have to cut in here. We have very little time left for a vote.

This hearing will recess for about 15 or 20 minutes, and then we will continue. I will have to ask the same panel to come back, because other Senators have questions to ask.

The hearing will be recessed until about 11:00.

[Whereupon, at 10:42 a.m., the hearing was recessed.]

## AFTER RECESS

The CHAIRMAN. Senator Roth, do you have any questions?

Senator ROTH. I have no questions, Mr. Chairman.

The CHAIRMAN. Senator Baucus, do you have any further questions?

Senator BAUCUS. I just have one further question, Mr. Chairman.

Ms. Lehnhard, what advice would Blue Cross/Blue Shield have when we move toward catastrophic coverage—and let us say we do—to avoid some of the confusion that necessarily and unfortunately will fall upon a lot of elderly Americans?

Today most elderly are still confused as to what is covered and not covered by Medicare. They are confused as to what their Medigap policies, if they have them, actually do cover compared to what Medicare covers. And if we also now, on top of that, enact a catastrophic plan—whether it is similar to the Administration's or another plan—how do we reduce some of the confusion that is going to necessarily fall to some of the seniors in this country?

I think that one of the biggest problems they have, in addition to acute illness and bills and so forth, is just the mental anguish and all the confusion as to what is and is not covered. How are we going to address that? How do you recommend that we address that?

Ms. LEHNHARD. I think, without question, there is going to be confusion. In fact, we are getting calls now from beneficiaries that think this has been enacted. I think it is going to call for an effort from everyone involved—the insurance commissioners in each State along with people who offer private coverage; the Medicare intermediaries and carriers are going to have to be prepared and funded for an onslaught of telephone calls from beneficiaries; I think providers and physicians are going to have to understand it, because they will get inquiries from their patients.

I would also say that, while on the one hand it will induce tremendous confusion, some of the things that are being looked at such as the elimination of the spell of illness or the change in the criteria for the home health benefit would serve to reduce some of the confusion that is out there over time; while, if there is an initial education period, it will take some of the complexity out of the program.

Senator BAUCUS. That is what I was going to suggest. Wouldn't it help, frankly, if there were less complexity?

Ms. LEHNHARD. There is no question. For example, one of our major sources of questions from beneficiaries is, "How does the spell of illness work?"

Senator BAUCUS. And if we move to the catastrophic coverage under Medicare, wouldn't that reduce some of the complexity that now exists, or would it?

Ms. LEHNHARD. Over time, after you have this initial education period. I would also say that intermediaries and carriers will have to do a tremendous amount of reprogramming and education. I think CBO has estimated that about $60 million will be needed to gear up for this catastrophic program.

Senator BAUCUS. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. First let me apologize for not being here at the beginning of the hearings, but we had some Finance Committee matters on the Senate floor that required my involvement.

Most of the catastrophic plans that are proposed are alleged to be market-displacing insofar as some of your businesses are concerned. To what extent is that really true? To what extent do you think you would still be able to sell first-dollar coverage and expanded coverage?

Obviously, even under what we are suggesting here or the Administration has suggested on catastrophic illness, there is going to be a substantial amount of money that still has to be paid by the individual.

Could I get some comments from any one of you?

Mr. CHILDERS. Mr. Chairman, I think there is a pretty good argument that a substantial portion of the private coverage would be displaced with any of the proposals adopted by Congress. Under the Administration's proposal, as I understand it, or Secretary Bowen's proposal, I believe there would simply be basically a $2000 exposure, plus some additional exposure for certain things that are not even now typically covered, like vision and hearing services and prescription drugs.

The CHAIRMAN. Prescription drugs, long-term care—you have a lot of things that are not covered.

Mr. CHILDERS. Long-term care, of course, is effectively uncovered even now, and so whether or not that would be covered is another issue, really outside the acute catastrophic care issue.

I would suggest to you that any of the proposals would make a substantial change to the private Medicare supplement marketplace.

Mr. POMEROY. Mr. Chairman, I think the NAIC viewpoint from regulators is that, yes, there will be a change, but there will still be a market, as you indicate. There still will be that $2000 loss exposure, for instance, if the Bowen Plan would be adopted, that people would want to insure against, and companies would move to make a product available.

We as insurance regulators would move quickly to make sure that the Baucus Standards apply to whatever new market is created by changes in Medicare.

Finally, I think that changes being discussed for catastrophic coverage will make it much easier for an individual to understand what their ultimate loss exposure is. If it is capped at $2000, they know that is their risk of loss, and they will be better able to assess whether they need coverage than they do presently, where it is a very confusing point of analysis for an individual to go through to determine whether they need the coverage or not. I think a simpler Medicare program will make it easier for an individual to decide whether they want coverage, and also to be able to price-compare between the various policies on the market.

The CHAIRMAN. Well, I really appreciate the role that the private sector plays in providing the elderly with some protection on health costs. I share your concern that we don't undermine your role.

But one of the suggestions that I understand you made, Mr. Moorefield, was that we should give the person the option of not taking the federal program if they have catastrophic coverage through their employer or by other means. Would that not leave the federal program with the sickest beneficiaries, those that are having the most problems? Wouldn't that raise the cost for those that remained? Would you respond to that?

Mr. MOOREFIELD. There may be some adverse selection there, sir, yes. However, you understand that this is a fall-back position, if you will, because we don't believe that the Medicare program should be restructured. But if it is the widsom of the Congress to do it, we think there should be that option for the beneficiary to elect to stay in the federal program, or go to the private carriers that offer broader coverage than any of the packages now proposed. Perhaps they would like that hearing aid, that vision testing, the balance-billing prescription drugs, even some of the long-term care home care benefits that are now beginning to be developed and appear in the marketplace.

So, we would urge that, if there is to be a restructuring of the current Medicare system, that there be that option. Yes, sir.

The CHAIRMAN. Let me understand this: You say that the private sector would offer broader coverage. By "offer" you mean some but not all policies, I would assume. How would we decide that this one is offering broader coverage, that this one is an adequate substitute? It seems to me you run into some serious mechanical problems in trying to do that.

Mr. MOOREFIELD. In your absence, sir, I proposed that first of all the way to go was to amend Baucus, to build the catastrophic into the Baucus Minimum Standards—unlimited benefits, and so forth. That would be the base, so we would know that everyone would have exactly what Medicare would propose. They could buy more, however, of the other types of benefits they wished and could afford.

The CHAIRMAN. I see. Thank you.

Are there further questions? Senator Heinz?

Senator **Heinz**. This is for Ms. Lehnhard.

Ms. Lehnhard, obviously one of the things we want to do is find a way to provide more in the way of catastrophic coverage, moving towards long-term care coverage if we can.

One idea that I don't think anybody has explored is the notion of having employers, at no cost to team, offer (as they do in the case of a group health or HMO plan) to everybody age 45 and over, let's say, a long-term care insurance option. Would the insurance industry be capable of providing such a plan for employers to offer?

Ms. **Lehnhard**. We are certainly looking at this. We have a couple of Blue Cross and Blue Shield products on the market for individuals, but not one yet that reflects the experience of that particular employer's group.

I think it is absolutely possible, to offer that kind of policy. We are recommending two tax changes to enable employers to help get this product on the market. We make these recommendations in our statement.

Senator **Heinz**. Well, the answer is that you might be able to do that?

Ms. **Lehnhard**. Yes.

Senator **Heinz**. Mr. Moorefield, would you be able to do that? And if so, how soon?

Mr. **Moorefield**. In fact it is being done. One of the major insurance companies up in Hartford is offering it to their own——

Senator **Heinz**. When you say it is being done, what do you mean?

Mr. **Moorefield**. Actual. The policies are there.

Senator **Heinz**. There are some long-term care policies out there to be marketed? I am talking about something a little different. I am talking about a law that would require all employers over a certain size in the United States to offer, at no cost to the employer, a long-term care insurance option. And the costs estimated by the Brookings Institution suggest that such a policy might be offered in the range of $50 a month, if—if—you start it at about age 45, and if there is competition among those kinds of plans.

Therefore, I am not asking whether or not something is being marketed; I know there are policies that are being marketed. I am asking whether the industry could really satisfy such a mandate responsibly at this point in time.

Mr. **Moorefield**. My answer would be Yes, sir. If they are doing it voluntarily, they could certainly do it under a mandate.

Senator **Heinz**. Thank you very much.

Let me ask you, Mr. Moorefield, on a related subject: How do you respond to the recent GAO report finding that loss ratios in commercial Medigap policies avegage only 60 percent, despite the fact that most states require much higher loss ratios? Isn't this finding, in some sense, an indictment of commercial policies, not to mention state enforcement activities?

Mr. **Moorefield**. We don't read the GAO report that way, sir. We had quite a discussion here on the loss ratios, and those several companies that were below the benchmark of 60 percent in anticipated. And as the Commissioners reported to the committee, there is now a form that the NAIC and all states are using that will cause companies to report their actual experience.

Most of the GAO data was accumulated over a very short period of time. For some of those companies, we understand through hearsay—not directly from them—it was one of their newer policies and therefore they had not developed the necessary experience to show it adequately. I am not criticizing the GAO report, but I am just making that observation, sir.

We believe the proper ratio should be at least 60 percent, and I think under the Commissioners proposal to look at actuals, we will see the companies rising to that or otherwise changing the premiums.

Senator HEINZ. The HHS Inspector General in his memo dated February 10, 1987, has suggested to Secretary Bowen that the profits by insurance companies may be adequate to fund a catastrophic benefit without an increase in premiums. What is your reaction to that?

Mr. MOOREFIELD. Again, sir, we have several companies that have already offered publicly, through public announcement in the press, that they are now adding the Bowen Proposals to their existing policies without cost.

Senator HEINZ. And can we expect that to take place broadly?

Mr. MOOREFIELD. I would think the competition will encourage them to do so, sir.

Senator HEINZ. And how will that help the people who do not now have Medigap coverage?

Mr. MOOREFIELD. It wouldn't help the people without Medigap coverage, sir; but 70 percent of the population does have Medigap coverage, another 10 percent are covered by the Medicaid program. Of the remaining 20 percent, half of that group can afford it but for whatever reason elect not to buy. So we suggest, sir, that the proper focus of this committee should be on the 10 percent who do not have Medicaid, cannot afford the Medigap coverages.

Senator HEINZ. And you have submitted a plan to do that?

Mr. MOOREFIELD. Yes, sir, it is in our statement.

Senator HEINZ. Thank you. My time has expired.

The CHAIRMAN. Senator Bradley?

Senator BRADLEY. Thank you very much, Mr. Chairman.

I would, if I could, explore with you a little bit on the catastrophic coverage of low-income persons. Basically, the proposal by the Administration deals with acute care, and it is financed by an additional premium to be paid by the Medicare recipient.

I have a question for you. First of all, acute care is only a part of the total picture. There is also a very great and increasing need to have home care coverage. So, if we were to address that as well in this proposal, and we financed it by the same means, that would imply an even larger premium that the senior citizen would have to pay. My question is: In both of those circumstances, what do you do about the very low-income person who can't pay the increased premium? What thoughts have you given to that, and what are your suggestions as to how we might finance that? And if I could, I would like to ask Ms. Lehnhard to answer that question.

Ms. LEHNHARD. Senator Bradley, we are supporting folding in catastrophic benefits into Medicare, only because that is the only way we feel you can reach the low income. We think the purpose is defeated if the premium becomes unaffordable for the low income because they may lose their entire Part B coverage, which means they have no access at all to the outpatient coverage.

We have supported taking the cost of the catastrophic program and having it financed through a premium surcharge every year that is related to income. In other words, when you file your tax return, you check a box. If your income is a certain amount, you pay a little bit more than other people, only for the cost of the catastrophic benefit. In this manner the 97 or 98 percent participation rate in Part B doesn't drop down because people can't afford it.

Senator **Bradley**. So, what you are suggesting is that ability to pay be applied to the issue of the premium?

Ms. **Lehnhard**. Yes, but only to the cost of the new catastrophic benefits. That is why we oppose taxing the actuarial value, because it is very open-ended.

Senator **Bradley**. So, you would say that people with higher incomes would pay a higher premium?

Ms. **Lehnhard**. That is right, and only because if you don't do that, even $6 or $10 may be too much for somebody to keep buying Part B.

Senator **Bradley**. Does anyone else on the panel have a thought about the proposal that Ms. Lehnhard has mentioned?

Mr. **Moorefield**. The commercial insurers have a different thought, sir, than our good friend with the Blues on how to finance it. We believe, speaking of the over-age-65 that I think you are limiting your question to, sir, the low-income there and buying in, we recognize that those 3-5 million people have to have some subsidy to get the coverage. There can be a direct subsidy which we will have to pay for through tax or otherwise, but the other alternative is to provide it through the Medicaid program.

I wish I could give you the figure of what it would cost to bring those 3 to 5 million in, but I can only give you somewhat of a related example, if you will.

There are some 31 states now under Medicaid that have the eligibility below the poverty level—50 percent below the poverty level. So, there are some of those who are categorically eligible to participate; but, since they are more than that 50 percent of the poverty level, they are excluded.

It is estimated by figures that I have recently seen that it would cost $2 billion to bring all those people in—$2 billion. We think that if you restructure the Medicaid type of program to bring in the low income, whether over age 65 or below, that is a possibility. We believe that we can eliminate the spend-down of the 500,000 people that annually spend down to get into Medicaid for nursing home coverage, so that it would be savings.

Senator **Bradley**. So, basically you are saying to increase Medicaid to cover this.

Let me ask the last two witnesses: You have a choice, a very clear choice that the previous two witnesses have presented. As I take what Ms. Lehnhard said, it is basically "make those people who have more money pay a higher premium, and that higher premium would take care of the low-income person." Mr. Moorefield has said, "No, increase what the Federal Government spends on Medicaid to cover the vulnerable at the low-income level."

Which of these two options make sense to you?

Mr. CHILDERS. Well, Mr. Chairman, I am not sure that the National Association of Insurance Commissioners has a public position on which approach might be the better one.

Senator BRADLEY. Well, you are the third witness on the panel. So otherwise—[laughter.]

Mr. CHILDERS. But I can give you my own personal opinion, and that is that in my view the best approach would be through altering the premium mechanism, based upon income, rather than increasing the cost of the Medicaid program.

Mr. POMEROY. Senator, that would also be my personal opinion as an insurance regulator. The insurance regulators, we are the policemen in the marketplace; it is basically not our position to formulate the answers to these sorts of questions. I have a personal concern about the regressive nature of the flat premium, the reduced Medicare benefit or Social Security benefit for the increased catastrophic portion of the Medicare. Your point is very well taken there.

And as to those who can't afford health insurance, it is not a problem that is being addressed privately or at the state level, and it is a very serious problem.

Senator BRADLEY. Thank you all very much.

Senator Mitchell?

Senator MITCHELL. Thank you, Senator Bradley.

I have a statement that I would like to have placed in the record, and I ask that that be done. I apologize to the witnesses; I was chairing a hearing in the Environment Committee, to which several of the members who were here have just gone to enable me to come down here.

I understand you have answered many of the questions that I had in mind. Let me ask you just one. What are defined as "catastrophic costs"—that is, those costs paid for by the individual outside the Medicare or Medicaid system—for both acute and long-term care are now largely paid for by the elderly or their families; as self-pay. What we are really talking about is redistributing the burden so that everyone pays something and no one is forced to pay everything.

Do you think that the elderly as a group are in a position to pay more, in the aggregate, than is now being paid, either in the form of insurance premiums for a private policy or in taxes to support a public program?

Ms. LEHNHARD. Senator, our position is that the lower income can't pay more. We don't know what the threshhold is, but there is some percentage that can't afford even $5 or $6 more for basic Medicare coverage. And to add on catastrophic may mean they lose some real solid benefits under Part B of Medicare.

There is, however, a large percentage of the over-age-65 population and their families that would be delighted to pay for a good long-term care insurance policy. We think there is a big market out there, and I know that Mr. Moorefield has a few more products on the market than we do at this point and believes that also.

Senator **Mitchell**. What would you think about a government program, via Medicare, which would provide for long-term care with a strict eligibility test, and would impose a premium and other forms of revenue raising—say through taxes—to support it, but would both reduce the cost of the program and enable private insurance to operate by having a substantial deductible period in time? Say, once a person is deemed eligible, the program would pick up the cost beginning 6 months, 9 months, 1 year, 2 years in the future? Would that help you sell insurance, by defining the risk for you as in point of time, or would you regard that as the kind of thing you would not want to see happen?

Mr. **Moorefield**. I think that we could support either that front-end—the government coming in at first for a period of time and then the commercial take it—or maybe it would be cheaper for the government to let the commercials take the front end and you pick up the back end, for the long-term period.

Senator **Mitchell**. That is what I was suggesting.

Mr. **Moorefield**. Yes, I think we could support that.

Senator **Mitchell**. You could support that, then?

Mr. **Moorefield**. Yes.

Ms. **Lehnhard**. Senator, I would say we are also looking at that, and I would say that the period that Medicare could pick up after us would probably be closer to five years. At present the market in the private sector seems to run around five years, and beyond that there are a lot of unknowns, and I think everybody is afraid to venture further than that at this point.

Senator **Mitchell**. Well, I have to say that I don't think that length a period of deductible in point of time would be acceptable politically. I don't think it is realistic, because you really would reduce it to a very small number of persons. But I appreciate your comment.

Mr. Childers, do you have a comment on that?

Mr. **Childers**. Yes, Senator, I do. As you may be aware, the Secretary of the Department of Health and Human Services appointed a task force to deal specifically with long-term care issues, and one of the issues that we have looked at is that specific aspect of long-term care, whether or not it should be rolled into the Medicare program.

I think I am perhaps not as optimistic as some of the others on the task force that the private sector will ultimately take up a lot of the slack, or will take off some of the pressure on the Medicaid program right now. As you know, about 1 to 2 percent of the total long-term care bill in this country is being picked up by private insurance.

I believe the Brookings Institute concluded that, even under the best of circumstances, they couldn't see more than 7 to 10 percent or so of that figure being picked up by the private sector market.

So, after all of that, I would suggest to you that your approach would probably make a lot of sense, that if we could get a reasonable premium—there is a conception on the part of the public right now, certainly a big part of the public, that they are already being covered for long-term care needs under the Medicare program, and making that a reality makes a lot of sense to me.

Mr. **Pomeroy**. Senator, basically I would just concur with what Director Childers told you. I used to be a state legislator, and I could tell you there is a lot of travail out in state legislatures about the Medicaid program and the states' share of it.

I appreciate your concern and the concern of the Congress in looking at how long-term care is financed. The present Medicaid program, in my judgment, can't continue to pick up this burden.

Senator **Mitchell**. Well, from the insurance standpoint, isn't the biggest problem now the uncertainty of the risk? And if you have a public program which defines precisely the risk and limits your exposure to that, you could very easily then tailor policies. It would be another gap that you could fill. I would think it would be something that your industry would support.

Mr. **Moorefield**. Yes, sir.

Senator **Mitchell**. Thank you, Mr. Chairman.

The **Chairman**. Thank you.

Thank you very much for your testimony.

On our next panel is Mr. Burt Seidman, who is the Director of the Department of Occupational Safety, Health and Social Security of the AFL-CIO; Mr. Patrick Killeen, the Assistant Director of Social Security Department, International Union UAW; Mr. Robert Hungate, the Manager of Government Affairs, Health Care, Hewlett Packard Corporation, California, on behalf of the National Association of Manufacturers; and Gail Shearer, the Manager for Policy Analysis, Consumers Union, Washington, D.C. Would you please come forward and take your seats? Mr. Seidman, would you lead off, please?

## STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF OCCUPATIONAL SAFETY, HEALTH AND SOCIAL SECURITY, AFL-CIO, WASHINGTON, DC, ACCOMPANIED BY CALVIN JOHNSON, MEMBER OF THE LEGISLATION SECTION

Mr. **Seidman**. Thank you, Mr. Chairman.

With me is Calvin Johnson, who is a member of the Legislative Department of the AFL-CIO. I have a prepared statement, and I respectfully request that it be included in the record of the hearing, and I will summarize it briefly.

The **Chairman**. That will be done.

Mr. **Seidman**. The AFL-CIO is pleased to have this opportunity to testify in support of providing Medicare beneficiaries protection against catastrophic medical expenses.

We commend you, Mr. Chairman, and your colleagues for moving expeditiously to address this problem, which the AFL-CIO Executive Council considered at its meeting last month. I have attached to my testimony the statement on catastrophic health insurance which the Executive Council unanimously adopted, and I respectfully request that it be included in the record of the hearing.

The **Chairman**. That will be done.

Mr. **Seidman**. Adding catastrophic protection to Medicare would help to address a serious unmet need. Although the AFL-CIO fully supports this goal, we have reservations about some of the financing mechanisms being proposed and would like to suggest an alternative for the committee's consideration.

Congress and this committee have chosen to begin to address the deep-rooted problem of access by improving coverage under Medicare. We also urge you to address the needs of the uninsured and begin exploring alternatives for addressing the problem of long-term care.

The AFL-CIO has developed a program for improving access to health care services for workers and their families without health care protection, which is also attached to my statement, and I respectfully request that that statement be included in the record of the hearing.

The CHAIRMAN. That will be done.

Mr. SEIDMAN. We are encouraged that the issue of protecting Medicare beneficiaries against the prospect of financial ruin associated with a serious illness has come to the forefront of public concern. Rising health care costs, gaps in coverage services, and changes in the practice of medicine require senior citizens now to pay more out of pocket as a percent of income than they did prior to Medicare's enactment. For people with catastrophic illness, the financial burden is even greater. They must pay high co-payments for long hospital stays, and a serious illness can completely exhaust their benefits. For physician services, there is no upper limit on their financial liability.

Essential services—including preventive care, substance abuse treatment, eyeglasses, hearing aids, prescription drugs and long-term care are not covered by the program.

We view providing protection against catastrophic illness as a needed and important first step, but strongly urge the committee not to limit its action to acute care. We support expanding Medicare to cover all essential services required by beneficiaries, especially preventive care and prescription drugs. We also urge Congress to begin to examine ways for beneficiaries to obtain protection against the cost of long-term care, especially needed health care including chronic care following an acute care episode. We do not believe that eligibility for long-term care should be linked to a hospital stay. Both community-based treatment and home care alternatives to nursing home care should be available whenever appropriate.

Mr. Chairman, doing away with existing co-payments for hospital care and limitations for covered days would make the Medicare benefit package more relevant to today's medical practice patterns. We also support limiting the out of pocket burden on Medicare beneficiaries to a single annual deductible indexed to the Social Security cost-of-living adjustment.

Finally, we recommend eliminating the existing but totally arbitrary cutoff of payment for hospice care after 210 days, decoupling the inpatient deductibles and the co-payment requirement for skilled nursing home care, and capping the out of pocket obligation for Part B services at as low a level as possible.

For retirees who currently receive catastrophic protection under employer health benefit plans, we would favor adding a provision to the bill that would require employers, through the end of the existing contract, to continue benefits that would in the future be provided by Medicare.

The AFL–CIO has fundamental concerns about proposals to tax a proportion of the actuarial value of Medicare benefits. In our view, taxing the value of Medicare benefits would be a precedent for taxing fringe benefits provided to individuals in the work force.

We recently fought and won a tough battle to preserve the tax-free status of health care benefits provided to employees, and we would strongly oppose introducing that concept into Medicare. Instead, we would propose that the committee consider a premium-based system with a refundable tax credit for low-income beneficiaries.

Mr. Chairman, we are prepared to work with you and your staff to develop this financing mechanism to extend long overdue coverage for catastrophic expenses to Medicare beneficiaries.

Thank you.

The CHAIRMAN. Thank you, Mr. Seidman.

Ms. Shearer, would you proceed, please?

[Mr. Seidman's written prepared testimony and attachments follow:]

87-14

## TESTIMONY BY BERT SEIDMAN, DIRECTOR
## DEPARTMENT OF OCCUPATIONAL SAFETY, HEALTH AND SOCIAL SECURITY
## BEFORE THE SENATE FINANCE COMMITTEE
## ON CATASTROPHIC HEALTH INSURANCE

**March 26, 1987**

The AFL-CIO is pleased to have this opportunity to testify in support of providing Medicare beneficiaries protection against catastrophic medical expenses. We commend you, Mr. Chairman, and your colleagues for moving expeditiously to address a problem which theoretically affects only a small segment of the elderly population but in reality, because of the financial devastation catastrophic illness can cause, the threat of it is uppermost in the minds of elderly citizens. This is a matter with which the AFL-CIO Executive Council was concerned at its meeting last month. I have attached to my testimony the statement on catastrophic health insurance the Council unanimously adopted.

Adding catastrophic protection to Medicare would help to address a serious, unmet need. Although the AFL-CIO fully supports this goal we have reservations about some of the financing mechanisms being proposed and would like to suggest an alternative for the Committee's consideration.

First some general comments. As you know, the risk of catastrophic expenses confronts Americans in three ways:

- Millions of individuals throughout their working lives and/or after they retire and before becoming eligible for Medicare remain without any health protection. For them even a trip to the doctor and several diagnostic tests can be out of reach financially.
- Medicare beneficiaries may require long hospital stays and repeated physician consultations resulting in out-of-pocket expenses which greatly exceed what Medicare or their private supplemental plans cover.
- Individuals of all ages, especially senior citizens, who have chronic conditions or are in need of long-term care have, with the exception of those who are or become eligible for Medicaid, little, if any, protection against the financial devastation that a long illness can cause.

Congress and this Committee have chosen to begin to address the deep-rooted problem of access by improving coverage under Medicare. We also urge you to take action to address the needs of the uninsured and begin exploring alternatives for addressing the problem of long-term care. The AFL-CIO has developed a program for improving access to health care services for workers and their families without health care protection which also is attached to my statement.

We are encouraged that the issue of protecting Medicare beneficiaries against the prospect of financial ruin associated with a serious illness has come to the forefront of public concern. Medicare itself was modeled after the basic insurance packages of the early 1960's and was designed to cover only short-stay acute care. Today advances in medicine have led to better control of chronic conditions and longer life spans. Rising health care costs, gaps in covered services and changes in the practice of medicine have resulted in senior citizens now having to pay more out-of-pocket as a percent of income than they did prior to Medicare's enactment. For people with catastrophic illness, the financial burden is even greater. They must pay high co-payments for long hospital stays and a serious illness can completely exhaust their benefits.

For physician services, an elderly couple must pay an annual premium of $430 each and each satisfy a $75 deductible before becoming eligible to receive benefits that require a 20 percent co-payment. However, there is no upper limit on their financial liability and essential services including preventive care, substance abuse treatment, eyeglasses, hearing aids, prescription drugs and long-term care are not covered by the program.

The AFL-CIO has long questioned the equity of penalizing the most seriously ill people by requiring steep out-of-pocket payments for long hospital stays and extensive physician treatment and by terminating benefits for catastrophically ill patients who need inpatient care. We view providing protection against catastrophic illness as a needed and important first step, but strongly urge the Committee not to limit its action to acute care. We support expanding Medicare to cover all essential services required by beneficiaries, especially preventive care and prescription drugs.

We also urge Congress to begin to examine ways for beneficiaries to obtain protection against the cost of long-term care. Recent studies have shown that once an indidividual reaches the age of 65 there is a one in five chance that he or she will need nursing home care. Unfortunately, 70 percent of senior citizens mistakenly believe that Medicare covers long-term care. With the median income for families headed by individuals over 65 at approximately $14,000, senior citizens cannot afford to remain unprotected for long-term care. Nor can most of them at the onset of their need for long-term care qualify for Medicaid. That patchwork system requires individuals to virtually pauperize themselves before becoming eligible for protection.

The AFL-CIO believes that Congress must take steps to address the long-term care needs of Medicare beneficaries, especially needed health care, including chronic care, following an acute care episode. We do not believe that eligibility for long-term care should be linked to a hospital stay. Both community-based treatment and home care alternatives to nursing home care should be available when appropriate.

Mr. Chairman, doing away with existing co-payments for hospital care and limitations for covered days would make the Medicare benefit package more relevant to today's medical practice patterns. We also support limiting the out-of-pocket burden on Medicare beneficiaries to a single, annual deductible indexed to the Social Security cost of living adjustment. This would protect beneficiaries from having to absorb any future increase in the deductible which far exceeds their ability to pay. In addition, we recommend eliminating the existing (but totally arbitrary) cut-off of payment for hospice care after 210 days; de-coupling the inpatient deductible and the co-payment requirement for skilled nursing home care; and capping the out-of-pocket obligation for Part B services at as low a level as possible.

Although we recognize the good intentions of some to develop a progressive financing mechanism to raise revenues to defray the cost of these benefits, the AFL-CIO has some fundamental concerns about proposals which call for taxing a proportion of the actuarial value of Medicare benefits. Unlike Social Security where individuals receive cash payments, Medicare provides an entitlement to service benefits. Depending on their health status, beneficiaries may or may not incur health care costs entitling them to benefits. In our view, taxing the value of Medicare benefits would be a precedent for taxing fringe benefits provided to individuals in the workforce. We recently fought and won a tough battle to preserve the tax-free status of health care benefits provided to employees and would strongly oppose introducing that concept into the Medicare program.

Instead, we would propose that the Committee consider a premium-based system with a refundable tax credit for low income beneficiaries. Congress has already provided an earned income tax credit to low-income single parents. This is a valuable precedent for our suggestion.

Like the earned income credit, we would propose that a credit be provided to low-income beneficiaries to assist them in financing the cost of the proposed new Medicare benefits. Such a credit should come off the bottom of the tax return and not involve any type of up-front deduction. To design the most progressive system, we would suggest that Congress provide a full credit to households with incomes under 100 percent of the poverty line and gradually phase out this relief as adjusted gross income increases. This would mean that over a certain income level (for example, 150 percent of poverty), the credit would be phased out.

Mr. Chairman, we are prepared to work with you and your staff to develop this financing mechanism to extend long overdue coverage for catastrophic expenses to Medicare beneficiaries.

For retirees who currently receive catastrophic protection under employer health benefit plans, we would favor adding a provision to the bill that would require employers, through the end of the existing contract, to continue benefits that would in the future be provided by Medicare.

## Statement by the AFL-CIO Executive Council

on

## Health Care Coverage

February 19, 1987
Bal Harbour, FL

While the United States leads the world in high-technology medical care, too many Americans lack access to even the most basic health care services. Currently, 16 percent of our population, or 37 million people, are uninsured, a 40 percent increase since 1980. Another 50 million have inadequate health insurance protection.

Workers and their families constitute three-quarters of those without coverage and a substantial number of the underinsured. Many employers make matters worse by cutting health benefits, offering inadequate coverage or refusing to provide any health benefits. The refusal of some employers to offer health care protection forces many workers and their families to postpone seeking care until their long-term health or even their lives are in jeopardy.

Most uninsured enter the health care system only through the doors of hospital emergency rooms. In the past, hospitals passed on the cost of their treatment by increasing charges paid by employer health benefit plans. Recently, hospitals have been less willing to shift these costs because of their desire to be more competitive by offering discounts to large health care purchasers. This has reduced the number of plans that absorb the cost of uncompensated care, making it harder for hospitals to pay for care of the uninsured.

The failure of employers to provide health insurance endangers the health of millions of workers and their families. This practice has established an economically inefficient system in which the last and only resort of the uninsured is to be treated in a hospital--the most expensive health care setting--and it has allowed the burden of financing care for the working uninsured to fall disproportionately on companies which provide protection.

We call upon Congress to:

* Require employers, as a condition of doing business, to assure a minimum package of specified health care benefits to all workers and their dependents, including part-time and laid-off workers. Employers could meet the statutory requirements by assuring health care benefit packages generally equivalent to the standards specified in the legislation.

* Provide financial assistance to low-wage employees to assure their health care protection.

* Limit the maximum out-of-pocket employee cost for the basic package.

* Preempt state laws governing insured plans.

* Require states to establish insurance pools through which employers that desire to do so could purchase the federally mandated benefits at an affordable cost.

* Require states to establish a separate pool so that those who, as a result of existing medical conditions or prior health care histories, have been unable to purchase insurance protection can obtain affordable coverage.

* Allow unions in collective bargaining to improve upon the minimum federal requirements.

The AFL-CIO continues to believe that the most effective way of reducing health care costs, improving access and assuring quality would be for Congress to enact a national health care system. In the meantime, we will work for legislation that will assure access to basic health care services for working Americans and their families.

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Fact Sheet on AFL-CIO Proposal to Mandate Employer-Provided Health Care Coverage

# FACT SHEET

# ON

# AFL-CIO PROPOSAL TO MANDATE EMPLOYER-PROVIDED HEALTH CARE COVERAGE

## Summary of AFL-CIO Proposal

The AFL-CIO calls upon Congress to pass legislation to provide a minimum package of health care benefits for employees and their dependents.

- Employers would have the option of assuring coverage through their own plans or multi-employer plans, purchasing coverage through an insurance pool which would be established in every state, or buying into the state Medicaid program.
- To retain flexibility for health plans to be designed to meet the special needs or priorities of specific groups, employers could meet the statutory requirements by assuring health care benefit packages that are generally equivalent to the standards specified in the legislation.
- Employers would be required to continue coverage for laid off workers for a specified period of time, which might be set at 4 to 6 months.
- Employers also would be required to assure coverage for part-time employees. There would be special provisions for cyclical industries and individuals working more than one job.
- All employees would participate in a plan.
- Financial assistance would be given to low-wage employees to assure their health care protection.
- Individuals without a direct relationship to the workforce (e.g., the long-term unemployed, early retirees, etc.) would be given the option of purchasing health care coverage directly through insurance pools established in their states.
- States would be required to establish a separate pool through which the so-called "medically uninsurable", those who have been denied coverage due to current medical conditions or prior health care history, could purchase protection.
- Through collective bargaining, unions and employers could improve upon the minimum federal requirements.
- This legislation would preempt existing state laws requiring that insured health plans offer certain benefits or cover of services of particular types of providers. It also would prohibit states from requiring employer-funded plans to offer services beyond those spelled out in the federally mandated package.

## Specific Provisions

**Coverage:** Employers would be required to assure health care coverage to full-time and part-time employees and their dependents. Employers would have the option of assuring coverage through their own plans or multi-employer plans, both of which could assure coverage directly (e.g., through an insurer, by self-insurance or by contracting with a health maintenance organization or a preferred provider organization) or purchasing coverage through a state insurance pool, which would be established in every state. States also could give employers the option of buying into Medicaid to assure the minimum package to their employees. All employees would be covered by health plans or Medicaid, and financial assistance would be given to low-wage employees to assure their health care protection.

**Minimum Benefits:** The minimum benefit package all employers would be required to assure would include hospital care, physician services, diagnostic tests, pre-natal and post-partum care, well-baby care up to age one, immunizations for children and prescription drugs for chronic conditions. Employers with health benefit packages that are generally equivalent to the minimum benefit package would not have to change those plans to meet the requirements of the legislation.

**Co-Payments:** There would be a ceiling on deductibles and co-payment requirements imposed on health services as well as a cap on total out-of-pocket payments for covered services.

**Cost Containment:** To meet the requirements of the federal act all health plans (including those funded through state insurance pools) would be required to have hospital precertification and utilization review programs and require second opinions for designated surgical procedures. All plans also would be required to coordinate the payment of benefits.

**Administration:** States would be required to establish two separate insurance pools. One pool would make it possible for employers to purchase the basic federally mandated benefit package at a lower rate than they could otherwise obtain on their own in the insurance market. The second pool would offer protection to those, who because of prior health care histories, have been unable to purchase insurance coverage. States would be required to offer a choice of coverage options through their state pools, including at least one managed care plan such as a health maintenance organization or a preferred provider organization. Pricing of each option would be on a community-rated basis. At their option, states could establish a premium for a Medicaid buy-in for acute care services for employer groups.

**Federal regulatory uniformity:** Existing state laws requiring insured health plans to offer certain benefits or coverage of services of particular types of providers would be preempted. In addition, states would not be allowed to require employer-funded plans to offer benefits beyond those spelled out in the federally mandated package.

**Collective Bargaining:** Through collective bargaining, unions and employers could improve upon the benefit package, financing requirements and other provisions of the legislation.

## Statement by the AFL-CIO Executive Council

## on

## Catastrophic Health Care Protection

February 19, 1987
Bal Harbour, FL

More than 20 years after the enactment of Medicare, there is a national consensus that the elderly and disabled need protection against the prospect of financial ruin associated with catastrophic illness.

Rising deductibles and co-insurance, gaps in covered services and changes in the practice of medicine are forcing senior citizens to pay more out-of-pocket as a percent of income than they did prior to Medicare's enactment. For people with catastrophic illness, the out-of-pocket burden is even heavier. Once they experience a serious illness, beneficiaries quickly exhaust Medicare benefits.

Congress is examining proposals to improve Medicare by protecting beneficiaries against catastrophic expenditures for acute care and by providing coverage for other essential services, such as preventive care and prescription drugs. The Reagan Administration is proposing a plan that is limited to catastrophic coverage. The AFL-CIO strongly supports the congressional initiatives. We are concerned, however, that the current congressional review does not include long-term care. Since one in five persons over 65 requires nursing home care, the lack of protection for long-term and chronic care is a major gap in Medicare coverage.

Protection against catastrophic illness and provision of some other services are a needed and an important first step. We will continue to work to expand Medicare to include all necessary health care services, including long-term care provided at home, in community-based treatment centers and in nursing homes.

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## STATEMENT OF GAIL SHEARER, MANAGER FOR POLICY ANALYSIS, CONSUMERS UNION, WASHINGTON, DC

Ms. SHEARER. Mr. Chairman, members of the Senate Finance Committee, I am Gail Shearer, Manager for Policy Analysis for Consumers Union, the publisher of "Consumer Reports" magazine. We greatly appreciate the opportunity to share our views with you concerning catastrophic health insurance and the private Medicare supplement market, or Medigap.

We are pleased that Congress is considering a modest improvement in Medicare that would limit the expenses of the elderly for certain covered costs. We urge you to address the problem of long-term care expenses which impose a severe burden on the elderly. At the same time, we urge this Committee not to lose sight of the crisis in health care access for the 37 million non-elderly Americans without any health insurance whatsoever.

At your hearing last week, the American Medical Association recommended increased reliance on the private market to fill in Medicare's gaps and to provide catastrophic coverage. In contrast, we have concluded that the consistent failure of the Medigap market to meet the needs of health care consumers clearly justifies an expanded role for the Federal Government in establishing catastrophic illness and long-term care protection.

Medigap policies tend to be high-cost low-value policies. Premiums range from $150 to $1500 per year. The cost of marketing, administration, and profits consume 40 percent of the premiums collected. By way of comparison, as you heard this morning, Medicare's administrative costs are 3 percent of revenues.

Consumers Union has always valued highly the benefits that healthy private markets can bring to consumers—low prices, high quality, and product innovation. While Consumers Union often makes suggestions to federal agencies about improving regulations to increase safety or about enforcing antitrust laws, we do not rush to conclusions that private markets are not fixable and should be replaced by an expanded government. However, the poor track record of Medigap in its failure to serve consumers compels the conclusion that an expanded government role is justified.

Last year the House Subcommittee on Health and Long-term Care estimated that older Americans waste $3 billion annually on Medigap policies because of duplicative health insurance policies and low loss ratios. As you know, loss ratios are the percentage of premiums collected that are paid in benefits. Through the years, abuses in the Medicare supplement market have been exposed by the House and Senate Select Committees on Aging, the Federal Trade Commission, and several state insurance departments. And, as has been discussed this morning, the Congress passed the Baucus Amendment in 1980, which established standards and target loss ratios for Medigap policies. Notwithstanding this initiative, GAO reported recently that loss ratios of 64 percent of Medigap policies were below the target level. Forty percent of commercial policies have loss ratios below 50 percent. The report found that states were not monitoring actual loss ratios of the companies, but rather accepting the companies 'expected or anticipated loss ratio to determine whether sufficient benefits were being paid out to consumers.

Many Medicare-eligible continue to be sold overlapping duplicative policies. Our San Francisco office recently identified a 79-year-old woman with five overlapping Medigap policies, three nursing home policies, and one hospital indemnity policy, amounting to $6500 per year in premiums. Other couples were found to have $10,000 and $13,000 worth of overlapping Medigap policies.

The Vice President of Medical Claims Services of America, a network of health claims assistance offices, recently reported that "Mediscare"—Mediscare, with an "s"—"insurance spending," the purchase of numerous policies, "is very common and can cost thousands of dollars per year, most of which is wasted."

We recognize that a catastrophic insurance program of the type proposed by Senator Dole and other Senators and Secretary Bowen would force Medigap policies to restructure their benefits and would displace a portion of their coverage. We welcome this shift, because we believe that an expanded Medicare can serve consumers far better than the private Medigap market. We urge you to consider ways to ensure the the newly designed gaps in Medicare do not lead to yet another round of victimization of consumers. We have outlined in our written statement some options for avoiding this. One option worthy of consideration is a voluntary federally-sponsored Medigap policy.

With regard to long-term care, we urge you to avoid repeating the mistakes of the Medigap market. Two options that we believe warrant consideration are, first, a voluntary Medicare Part C to cover long-term care needs, financed in part by a premium paid by participants and in part by cost-sharing; and, second, an expansion of Medicare to cover long-term expenses for all participants.

We don't sense that Congress presently has all the information it needs to act on the long-term care issue. We suggest that Congress include a provision in the catastrophic bill calling for a study of the full range of options, or possibly a Congressional Commission to recommend national long-term care policy.

Thank you.

The CHAIRMAN. Thank you very much.

Mr. Hungate, would you proceed, please?

[Ms. Shearer's written prepared testimony follows:]

# Testimony of
# CONSUMERS UNION
# before the
# COMMITTEE ON FINANCE
# UNITED STATES SENATE

hearing on

CATASTROPHIC HEALTH INSURANCE

March 26, 1987

Gail Shearer

Linda Lipsen

Mr. Chairman and members of the Committee on Finance, Consumers Union* appreciates the opportunity to present our views on the issue of catastrophic health insurance coverage under the Medicare program. This testimony will discuss the failings of the private medigap market and the inappropriateness of relying on it for catastrophic and long-term care coverage.

By way of introduction, we would like to note that Consumers Union -- publisher of Consumer Reports -- values highly the benefits that healthy private markets can bring to consumers: low prices, high quality, product innovation, to name just a few. Consumer Reports provides comparative product information with the goal of helping consumers function more knowledgeably when they purchase goods in the private market. This month's magazine, for example, rates (among other things) color TV's, several cars, soups, and steam irons. While Consumers Union often makes suggestions to federal agencies about improving regulations to increase safety or about enforcing antitrust laws, we do not rush to conclusions that private markets are not "fixable" and should be replaced by an expanded government.

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*Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide information, education and counsel about consumer goods and services and the management of family income. Consumers Union's income is derived solely from the sale of Consumer Reports, its other publications and films. Expenses of occasional public service efforts may be met, in part, by nonrestrictive, noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports, with approximately 3.5 million paid circulation, regularly carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

With this as background, the main point we would like to make in this testimony is that the private medicare supplement insurance market has failed. Despite numerous attempts by the federal and state government to improve its performance, the "medigap" market is wasting consumers' limited health care dollars. The House Subcommittee on Health and Long-Term Care estimated last year that older Americans waste $3 billion annually because of duplicative health insurance policies and low loss ratios. [Catastrophic Health Insurance: The Medigap Crisis, Hearing before the Subcommittee on Health and Long-term Care of the Select Committee on Aging, House of Representatives, June 25, 1986, p. 146] Because the private medigap market has performed so poorly, Congress should not hesitate to displace it when expanding Medicare's coverage of catastrophic expenses. In addition, Congress should not allow the emerging market for long-term care insurance to follow the medigap market's uninspiring model.

The acute and long-term health care needs of the elderly deserve immediate Congressional attention. However, we do want to point out that health financing problems faced by people under 65 are also severe and need to be addressed. 37 million people in our nation face limited access to health care because they do not have health insurance. Nearly 12 million of the uninsured are children. Between one quarter and one third of Americans are underinsured, and face the risk that out-of-pocket medical expenses will consume a large percentage of their income. [Margaret B. Sulvetta and Katherine Swartz, The Uninsured and Uncompensated Care, National Health Policy Forum, June 1986. p. 19] Inadequate access to health care at a reasonable cost is a major barrier to escaping poverty. Many working families live on the edge of poverty or actually fall into it because they experience high, unreimbursed health care costs. Many working people with incomes far above the poverty level are uninsured; 35% of the uninsured have incomes greater than twice the poverty level. We urge the Committee to consider ways to increase insurance coverage for all Americans.

## Poor Performance of the Medigap Market

The consistent failure of the medigap market to meet the needs of health care consumers clearly justifies an expanded role for the federal government in establishing catastrophic illness and long-term care protection. In the late 1970's, abuses in the medicare supplement insurance market were exposed by the House and Senate Select Committees on Aging, by the Federal Trade Commission, and by several state insurance departments. In addition to marketing abuses such as "loading up" (selling multiple overlapping policies to vulnerable consumers), "twisting" (convincing a client to switch policies, thereby increasing exclusions for pre-existing conditions), "clean sheeting" (where agents ignore applicant's health problems on the application form, but leave the client vulnerable to having claims rejected later), the Federal Trade Commission found that medicare supplement policies very often had very low loss ratios (percentage of premiums collected that are paid in benefits). Moreover, it was revealed that people eligible for medicare supplement insurance policies were understandably confused about how to evaluate the available policies; and very little information about the worth of the policies existed.

In response to the documented abuses within the medigap market, the Congress passed the "Baucus Amendment" in 1980, adding section 1882 to the Social Security Act. State insurahce departments have also attempted to regulate this market, though with varying degrees of enthusiasm. Despite these efforts from federal and state governments, the problems still persist. The General Accounting Office recently reported that while the market has improved somewhat, loss ratios of most commercial policies were below the targets enunciated in the Baucus Amendment and averaged 60.2% in 1984. [Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies, General Accounting Office Report to the Subcommittee on Health, Committee on Ways and Means, October 1986, p. 4] In addition, the report found that most states do not monitor the actual loss ratio experience [GAO Report, p. 25].

Consumers Union continues to find abuses in this marketplace. On October 14, 1986, the San Francisco office of Consumers Union (joined by eight other organizations) filed a petition before the California Commissioner of Insurance to halt the unfair and deceptive marketing of medigap insurance to senior citizens. The petition claimed that unscrupulous agents in California had:

(1) loaded up senior citizens with overlapping policies;

(2) caused seniors to cancel policies and replace them with new ones creating lags in coverage;

(3) misrepresented themselves as being from government agencies or independent senior organizations; and

(4) exaggerated the coverage offered by policies and failed to disclose the substantial limits and exceptions to coverage.

State insurance commissions, the Department of Health and Human Services, and Consumer Reports (in a June 1984 article rating medigap policies) have attempted to educate consumers about medigap policies and their limits. But despite these efforts, consumers continue to be uninformed and purchase duplicative and low value policies. Consumers are confused, and for good reason. Medicare -- with its Parts A and B, coinsurance, deductibles, skilled nursing facilities, intermediate care facilities, benefit periods, lifetime reserve days, physician assignment, etc. -- is an impossible maze, defeating even the most educated consumers. It is no wonder that 70 percent of the elderly believe that Medicare would pay for long-term nursing home care. Adding to this confusion, consumers must comprehend a variety of private policies marketed to the elderly (often through deceptive marketing techniques)-- medigap policies, hospital indemnity policies, dread disease coverage. It should come as no surprise that research shows that the level of knowledge the elderly have about Medicare and private insurance is extremely low. [Nelda McCall, Thomas Rice, and Judith Sangl, "Consumer Knowledge of Medicare and Supplemental Health Insurance Benefits," Health Services Research, February 1986, pp. 633 - 657] Based on the medigap market's overall performance record, there is no justification to rely on it for catastrophic or long-term care insurance.

## Catastrophic Protection within Medicare

Consumers Union strongly supports the concept of restructuring Medicare to provide the elderly with protection against catastrophic illness. Secretary Bowen's proposal regarding catastrophic expenses of the elderly (and other similar proposals) would greatly benefit those individuals with the most severe medical expenses. With Medicare paying less than one half of the health care costs of the elderly, there is clearly a compelling need for this protection. The cost of catastrophic illness on the elderly often imposes a serious financial burden. Data contained in Secretary Bowen's Report indicate that 10% of the elderly have out-of-pocket health care liabilities of $1000 or more a year. [Bowen Report, p. 26] Additionally, this financial burden does not fall according to ability to pay. Expected out-of-pocket expenditures represent a much larger percent of income for low-income consumers than of higher income consumers. [Changing the Structure of Medicare Benefits: Issues and Options, Congressional Budget Office, March, 1983]

We recognize that a catastrophic insurance program of the type proposed by Secretary Bowen would displace a portion of medigap policies and would force many medigap policies to restructure their benefits. We welcome this shift to the public sector, because we believe that an expanded Medicare can serve consumers far better than the private medigap market. Medicare's administrative costs are 3% [The Medicare and Medicaid Data Book, Health Care Financing Administration, 1983, pp. 69,70], while administrative costs, marketing costs and profits for commercial medigap policies average about 40%. The private market has tried, and has been given more than enough time to rise to the challenge of serving consumers. But after years of abuses and ineffective regulation, we believe it is time to try another approach.

Most proposals for catastrophic illness protection continue to leave a sizable market left unfilled. We urge you to consider ways to ensure that the newly designed gaps in

Medicare do not lead to yet another round of victimization of consumers. There are several options worth considering. The first option is a Medicare-sponsored voluntary policy which would cover the $2000 (or $1000 to $1500) out-of-pocket cost-sharing expenses. This policy might also include (as an option the consumer could elect) coverage for prescription drugs and other types of costs not presently covered by Medicare. An expanded Medicare would save substantial marketing and administrative costs and deliver more health benefits per dollar to consumers. Further, a public sponsored program could alleviate the labyrinthian search process for high value, comprehensive coverage.

A second option is for Congress (or its designee) to design a standard medigap policy; the Department of Health and Human Services could be asked to select a private company to market and administer this policy, under a competitive bidding process. This would enable the private market to continue to play a role in serving this market.

A third option is to drastically upgrade the so-called Baucus amendment to require DHHS and/or the state insurance departments to enforce a genuine minimum loss ratio. The industry portrays the sense that the Baucus amendment established a minimum loss ratio of 60% for individual medigap policies. In fact, the Baucus Amendment only sets a target; few states even bother to monitor the actual loss ratio experience. It comes therefore as no surprise that most commercial policies have loss ratios lower than 60% (and many of these are far below 60%). If this option were adopted, we would urge the Congress to increase the minimum loss ratio sufficiently to drive out the poorly performing companies.

We hesitate to strongly recommend this third option because we are not confident that most regulators have the resources or the will to correct the abuses that have occurred for twenty years and will undoubtedly continue to exist. Even a high minimum loss ratio, effectively enforced, would not eliminate incentives for agents to sell numerous, duplicative medigap policies and dread disease and hospital indemnity policies which are not covered by the Baucus Amendment.

## Further Options for Long-Term Care Protection

Secretary Bowen's recommendations with regard to long-term care stress public education, tax benefits for personal savings, and tax subsidies to encourage the purchase of private insurance. We urge you to consider additional options. We fear that the private market will do no better with regard to long-term care than it has done with regard to medicare supplement insurance. Two options that we believe warrant consideration are first, a voluntary Medicare Part C to cover long-term care needs, financed in part by a premium paid by participants and in part by cost-sharing, and second, an expanded Medicare to cover long-term care expenses for all participants.

A voluntary Medicare Part C covering costs of long-term care has several advantages over private market coverage. They include: (1) lower administrative and marketing costs; (2) greater value for money for consumers because loss ratios would be much higher than equivalent private policies; (3) reduced consumer search costs and confusion resulting from inadequate information about the worth of products in the private market; (4) increased access for all of the Medicare-eligible population to long-term care coverage because no applicants would be turned down due to poor health. (In contrast, the private market would not be able to accommodate applicants that they believe are poor risks).

The second option that should be considered is expanding Medicare to cover long-term expenses for all participants. The key drawback to this option is the significant amount of new federal dollars that would be needed to finance it. (A good portion of the expense would be a shift from Medicaid spending to Medicare spending.) Through gradual phase-in of benefits and significant cost-sharing (possibly a portion of social security checks of those using long-term care services), the impact on the federal budget could be reduced. A proposal along these lines has been developed by the Harvard Medicare Project in Medicare: Coming of Age -- A Proposal for Reform [Harvard University, 1986].

Mr. Chairman, we appreciate the opportunity you have afforded Consumers Union to present its views on catastrophic health coverage under Medicare, and look forward to working with you on this important issue.

## STATEMENT OF ROBERT W. HUNGATE, MANAGER, GOVERNMENT AFFAIRS—HEALTH CARE, HEWLETT PACKARD CORP., PALO ALTO, CA, ON BEHALF OF THE NATIONAL ASSOCIATION OF MANUFACTURERS, ACCOMPANIED BY: SHARON CANNER, DIRECTOR OF EMPLOYEES' BENEFITS, NAM

Mr. HUNGATE. Mr. Chairman and members of the Senate Finance Committee, I am Bob Hungate of Hewlett Packard Company. Today I am appearing on behalf of the National Association of Manufacturers. Accompanying me is Sharon Canner, NAM's Director of Employee Benefits.

NAM supports the selective expansion of Medicare to provide catastrophic and acute care protection. There are caveats: First, the program financing must be adequate. Initiatives to expand coverage must fully recognize the three cost-escalating factors of continuing health care cost inflation, the growing elderly population requiring increased resources, and the relatively diminished pool of workers to support participants in the future. Existiog large federal budget deficits must not be increased by inadequate financing of costs.

While the program must adhere to strict cost-containment principles, provider payment must be adequate to ensure coverage of provider costs, so that government fiscal responsibility is not shifted to employers.

Second, we support the proposed scope, which is limited and provides the private insurance market encouragement to continue providing supplemental protection for drugs and other services.

NAM endorses the encouragement through tax incentives of the employer role in providing post-employment health insurance but strongly opposes any attempt to make employer plans primary for retired Medicare participants.

Let me comment briefly on how the current proposals will affect Hewlett Packard. We may not be representative of general industry conditions, since we are a fairly young firm.

First, we are self-insured for our health care costs, utilizing a third party administrator for claims processing. We encourage our eligible employees and retirees to subscribe to Medicare—it is not automatic. And when they subscribe, it is virtually all due; the premium is paid by the beneficiary. In effect, our Medicare beneficiaries have coordinated coverage.

As Medicare deductibles rise, the portion of that expense that we absorb increases. On the other hand, capping out the catastrophic cost will limit the amount we pay out in benefits. It is not easy for us to tell at this stage what the financial impact on the corporation will be, but we are sure that cost-shifting is a concern.

I should go on to point out that HP is a relatively young company. We have, by the end of this year, about 3300 retirees, and that compares to an active population in the U.S. of 52,000 employees. We have a ratio of actives to retired of about 14:1. That is in contrast with General Motors, with a ratio of 1.9 actives to 1 retired; Ford with 1.6:1; ARMCO, where it goes the other way, where for every active employee they have 1.2 retired; and USX who, for every active have 3.3 people in a retired pattern.

So, the individual corporations' situations with respect to how this works out are quite different. The ratios clearly express why manufacturers are so concerned about moves to make them primary payors for retiree health costs.

I should also reiterate that NAM's support for catastrophic acute care insurance coverage improvement is specifically for existing covered services. Long-term care is a more significant and pressing financial need, because so many more people are involved. It also has a much more significant unknown factor: The membership of NAM, including Hewlett Packard, is only beginning to look at how to work with our active and retired employee population to seek an effective solution to this extremely important quality-of-life need. The current debate is extremely helpful in raising public awareness so that good solutions will find a market in this area.

Recapping our position in support of the legislation to lessen the financial risk for Medicare beneficiaries, we favor careful costing and establishment of a fully-priced premium both now and in the future, continuation of existing current covered services. The program represents a responsible step in ensuring the financial security of the people that have been the strength of our country, and it deserves our support.

Thank you for this opportunity to present our views.

The CHAIRMAN. Thank you.

Mr. Killeen, would you testify, please?

[Mr. Hungate's written prepared testimony follows:]

Testimony of
Robert W. Hungate
Manager, Government Affairs - Health Care
Hewlett Packard
On Behalf of
The National Association of Manufacturers
On
Catastrophic Coverage for Medicare
Before the Senate Finance Committee
March 26, 1987

Mr. Chairman and members of the Senate Finance Committee, I am Robert Hungate, Manager, Government Affairs - Health Care, Hewlett Packard, Palo Alto, California. Today I am appearing on behalf of the National Association of Manufacturers. Accompanying me is Sharon Canner, NAM Director of Employee Benefits.

The NAM is an organization of over 13,500 corporations of every size and industrial classification located in every state. Members range in size from the very large to over 9,000 smaller manufacturing firms, each with an employee base of less than 500. The NAM is also affiliated with the National Industry Council which includes 135 state and local business associations representing 138,000 individual companies.

## The Medicare Program: Public-Private Sector Cooperation

From its inception in 1965, Medicare was designed as a cooperative effort between the federal government, private employers and American workers. A payroll tax of 1.45 percent (levied on a wage base of $43,800 in 1987) is paid by individual employers and their employees to finance hospital services, skilled nursing care and home health. (Part A).

For fiscal year 1988, the Administration has budgeted $81.9 billion which assumes enactment of certain legislative and regulatory changes. This figure represents a 4.8 percent increase over 1987 expenditures. Without these proposed changes, Medicare would grow 10.8 percent over 1987.

Part B (physician services) of Medicare is financed through a beneficiary paid premium covering 25 percent of program costs with general revenues making up the rest. Initially, the premium was intended to finance 50 percent of program costs, but, rapidly growing health care inflation quickly convinced lawmakers to enlarge the federal commitment.

Rapidly growing health care costs also spurred major payment reform in Part A in 1983 when the hospital prospective payment system replaced a cost-based system. Other cost control efforts included indexing the annual deductible for hospital care to medical inflation.

NAM strongly supports these cost management efforts to maintain the long term financial integrity of Medicare. It is important to recognize that the Medicare Trust Funds, while financially solvent at present, face an uncertain future. According to the 1986 report of the Medicare Board of Trustees, Medicare's hospital insurance trust fund is barely sufficient to ensure the payment of benefits and maintain the fund at a level of one-half year's disbursements over the next seven to nine years under moderate economic assumptions, and the fund will be completely exhausted in 1993 under less optimistic assumptions.

It is clear that the federal government is in no position to assume increased costs involving an expansion of Medicare services, nor should employers be expected to assume increased responsibilities when they are already struggling to maintain their position in global markets.

Inappropriate shifts of responsibility sometimes produce unintended consequences. An amendment to the Age Discrimination Act in 1982 required companies with 20 or more employees to continue to provide health insurance to workers 65 to 69. Employers were made the primary payer of health care benefits for this category of workers. Previous to passage of the amendment, firms with 100 employees or more had employed three-fourths of workers aged 65 to 69. This figure declined to two-thirds, a year later.

Further shifting of federal costs to the private sector should be avoided. Government should continue to be the primary payer of health care benefits for retired persons age 65 and over.

## The Private Sector and Post-Employment Health Benefits

In addition to sharing support for Medicare through payroll taxes and general revenues, the private sector has assumed substantial responsibility for providing health benefits to their retirees. Today 84 percent of employees of large firms and nearly half of those working for firms with 100-250 employees participate in health plans that continue health coverage after retirement. Currently, nearly seven million retired Americans and their dependents are covered by these health benefits.

Generally, corporate plans provide coverage to retirees and their families until age 65. After that age the plan is adjusted to recognize what Medicare provides. Often employers pay the Medicare Part B premium for their retirees. Many provide benefits to supplement Medicare (e.g., paying deductible or benefits after Medicare is exhausted).

The federal government has not offered much incentive for the private sector to provide post-employment health benefits. For example, the Deficit Reduction Act in 1982 severely limited the ability of employers to prefund post-employment health insurance for retirees. Prior to that time, certain tax incentives were available. For the private sector to continue its commitment to retirees, incentives such as those lost through DEFRA, should be restored. Such measures will assure continuation of private-public sector cooperation in providing health insurance protection for this group and avoid costly government expansion in this area.

Medicare and Catastrophic Medical Expenses

The prognosis for catastrophic medical expenses for the elderly is not good. Americans 65 and older will more than double between 1980 and 2040, and those 85 and older who are at greatest risk for chronic illness will increase an expected 20 percent over their numbers today. The need for sophisticated medical technologies, prescription drugs and similar items and services will grow while more people dependent on Medicare will severly strain the system.

Thus, it is timely to begin consideration of alternatives to provide protection for catastrophic medical expenses for the Medicare population. It is also obvious that cost constraints must underlie the program design which should be confined to Medicare covered serves only. While the need for long term nonacute custodial care is significant, federal commitments should not at this time, use limited resources for this purpose at the expense of providing basic acute care protection. Coverage of other nonacute care services should be maintained through the private insurance system. Commercial insurers and Blue Cross/Blue Shield should continue to improve their products to serve the market they are best suited to handle and limit further expansion of government entitlement programs.

## Catastrophic Insurance Proposals

Their is growing concensus for passage of catastrophic health insurance for Medicare beneficiaries. This discussion should recognize that resources are limited to provide currently promised benefits, while health care inflation continues its rapid increase--10.7% of GNP or a 8.9 percent increase over the previous year. Thus, it is essential to narrowly define any new program expansion.

The two major proposals--Bowen and Stark-Gradison--now under Congressional consideration, have wisely limited the scope of benefits to acute care services. NAM believes both approaches deserve careful study. Underlying this discussion is the need to make an accurate assessment of expected program costs. The federal government has a poor record for doing so. As early as 1967, the Medicare Board of Trustees reported that the Medicare program was some 0.28 percent of payroll tax higher than the official estimates of 1965, and recommended a payroll tax increase or the fund would be deleted by 1971.

Below, we offer a few comments on the differing approaches to financing catastrophic insurance and urge that Congress carefuly study the political, financial and social ramifications in making this important decision.

Premium Financing. The Reagan-Bowen plan would add an indexed premium of $4.92 per month to Medicare Part B. For the added premium, enrollees would receive unlimited hospital and physician care after a $2,000 out-of-pocket limit had been reached. This approach maintains the insurance concept of Medicare by encouraging risk sharing across the broadest possible base. The premium approach, to its advantage, also serves to focus attention on cost.

Because the premium and the out-of-pocket amount would both be indexed for inflation, there is some danger that Congress may find it politically difficult to accept scheduled increases.

Recently, when the Medicare deductible was scheduled to rise to $572 in 1987, Congress was quick to lower that amount to $520 and limit future increases. Estimates from the Congressional Budget Office on the Bowen plan recommend a premium of $6.40 for 1988. Thus, political courage may be needed sooner than expected.

Some elderly persons may not be financially able to pay $4.92 per month. For them, fees based on a sliding scale according to income, arrangements through Medicaid, or similar approaches should be explored.

Tax-Based Financing. Representatives Stark (D-CA), Gradison (R-OH), Rostenkowski (D-IL), and Duncan (R-TN) have proposed taxing 50 percent of the actuarial value of Part A and 75 percent of part B. Medicare's benefit package is currently valued at $1,800.

Taxation of benefits would avoid the use of general revenues should premiums prove inadequate. Congress could also avoid the painful decision of raising premiums to meet increased program costs. The equity question of lower income beneficiaries would be addressed since approximately 65 percent of elderly taxpayers would pay no tax.

It is important to note the Congress only recently made major changes to the tax code and re-opening the process could damage those changes before they are given a fair trial. Taxation also implies means testing. If the program is to be significantly altered in this direction, its impact must be more openly and fully explored.

A benefits tax raises other points, also. All Medicare enrollees of Part A (a nonvoluntary program) whether or not they elected to take Part B, would be taxed. Because this is a less visible payment method, there may be a temptation to increase program funding since financing will be less obvious to the public.

Of perhaps greatest concern is the dangerous precedent set by taxing Medicare benefits and its relationship to all health benefits. Historically, employment-based health insurance has enjoyed tax-preferred status for many reasons. Government, workers, and their employers have recognized the value of health insurance in insuring physical and emotional well-being. Eliminating tax preferences may persuade some persons to forego benefits rather than pay the tax. As such, taxation could undermine an important source of protection for 135 million Americans.

## Summary and Conclusions

NAM supports selected expansion of Medicare to provide catastrophic protection to Medicare beneficiaries for services presently covered by Medicare. Such initiatives must recognize rapidly rising health care inflation, a growing elderly population demanding increased resources, a relatively diminished pool of workers to support Medicare participants in the future, and large federal budget deficits. Program financing must be adequate to insure that costs not increase, government fiscal responsibility is not shifted to employers; scope of coverage is limited while the private insurance market is encouraged to continue providing supplemental protection; and the program design must adhere to strict cost containment principles. NAM strongly opposes any attempts to make employer plans primary for retired Medicare participants.

NAM is pleased to work with the Committee in developing a workable catastrophic health insurance program for Medicare beneficiaries. A major part of this effort is recognizing the important role played by employer-sponsored insurance for retirees and a continued need to provide incentives for doing so.

## STATEMENT OF PATRICK F. KILLEEN, ASSISTANT DIRECTOR, SOCIAL SECURITY DEPARTMENT, INTERNATIONAL UNION UAW, WASHINGTON, DC, ACCOMPANIED BY ALAN REUTHER, ASSOCIATE GENERAL COUNSEL, UAW, WASHINGTON, DC

Mr. KILLEEN. Thank you, Mr. Chairman. I will read a summary of our statement, and I would appreciate it if the full statement could be entered into the record.

I am here today with Alan Reuther, Associate General Counsel for the UAW from our Washington office. I am Assistant Director of the Social Security Department of the International Union UAW. We appear before you today on behalf of some 1.5 million active and retired members of the UAW and their families.

The UAW supports enactment of legislation to provide Medicare beneficiaries with protection against catastrophic expenses. Protection under Medicare has been seriously eroded over the years as a result of cutbacks by the Federal Government plus incessant medical care inflation. For example, the Medicare Part A hospital deductible has risen from $40 at the inception of the program to $520 today, as you well know.

The private insurance industry has not been able to provide adequate Medicare supplementary coverage at an affordable cost to millions of Medicare beneficiaries. Some 30 percent of the elderly and disabled have no insurance coverage to supplement Medicare, as has been pointed out. And as has also been pointed out, even for those who can afford Medigap policies, the return in benefits is apallingly low—some 60 cents in real benefits for every dollar of premium, compared to 97 or 98 cents on the dollar under Medicare.

The Reagan Administration has taken a small, timid, first step toward addressing these problems by endorsing the proposal put forward by Secretary Bowen. However, the $2000 stop-loss limit on Part A and Part B expenses under the Administration's proposal would only benefit the small number of Medicare beneficiaries who have an extended hospital stay. Thus, the proposal actually would provide only about one in 200 Medicare enrollees with any significant help. Many thousands of other beneficiaries on limited incomes would be bankrupt before reaching the $2000 stop loss.

In addition, as Mr. Seidman pointed out, expenditures for prescription drugs, long-term care, dental care, and preventive health services are not counted towards this maximum.

The UAW urges Congress to enact a package of improvements in Medicare which contain the following elements:

Removal of the limits on coverage for extended hospital stays; elimination or drastic reduction of the $520 Part A deductible; coverage of prescription drugs, especially maintenance drugs for chronic medical conditions, which alone can amount to annual costs of catastrophic proportions for many individuals; and a much lower stop loss than the $2000 figure in the Administration's proposal.

The UAW also calls upon Congress to begin to assess and address the problem of inadequate services for, and financial protection against, long-term disabilities, as other members of the panel have called for. In addition, measures to mandate or seriously strengthen assignment by physicians under Medicare need to be enacted, in order to prevent dilution of the intended protections.

In regard to financing, sufficient revenues can be generated to pay for needed improvements in the program through a number of steps, which could include recalculating the reimbursement rates for hospitals under the DRG system. A recent GAO study suggests that the profit margins of many hospitals are sufficiently high to justify a rebasing of the DRG system.

The UAW also supports a premium-based financing system with some provision to offset the costs to low-income persons. The UAW strongly opposes proposals to tax a proportion of the actuarial value of Medicare benefits. This would establish an unfortunate precedent for taxing all health care benefits provided by employers to their workers and retirees. Taxing Medicare benefits would also result in a substantial tax increase for a large portion of the elderly, and younger disabled people and their families. The imposition of such a tax increase would be particularly unfair to those senior citizens and younger disabled workers who, in many cases, already receive catastrophic protection through insurance policies that are entirely paid for by their employer or former employer.

In our judgment there would be strong resistance among the elderly to the imposition of new taxes on Medicare benefits especially since beneficiaries are not receiving any additional cash income and may not even use the health care benefits in a given year.

The UAW also opposes any steps toward conversion of Medicare to a means-tested program.

Again, we would like to thank the committee for the opportunity to present our views on this subject. We are anxious to work with the members of this committee in developing a package that will provide these much-needed improvements in the Medicare program.

[Mr. Killeen's written prepared testimony follows:]

March 26, 1987

Statement of

Patrick F. Killeen
Assistant Director, Social Security Department
International Union, UAW

on the subject of

## MEDICARE CATASTROPHIC HEALTH INSURANCE

before the

Committee on Finance
United States Senate

On behalf of:

International Union, United Automobile
Aerospace and Agricultural Implement
Workers of America, (UAW)

Mr. Chairman, my name is Patrick F. Killeen. I am Assistant Director of the Social Security Department of the International Union, UAW. I appear before you today on behalf of some 1.5 million active and retired members of the UAW and their families.

The UAW appreciates the opportunity to present our views on legislation to provide protection against catastrophic hospital and medical expenses under Medicare. We commend the Chairman and Members of this Committee for addressing a most serious national problem: financial devastation of thousands of disabled and elderly Americans due to the expenses associated with a catastrophic illness, as well as the widespread fear and insecurity among Medicare beneficiaries that such financial devastation could come to them and their families.

## The Need

The UAW supports enactment of legislation to provide Medicare beneficiaries with protection against catastrophic expenses; however, we have serious concerns about a number of the specific proposals which have been suggested.

The prospect of such legislation represents a healthy and positive response to the following problems:

- The proportion of disposable income which the elderly must spend for medical services has grown in recent years so that it is now greater than before the enactment of Medicare in the mid-1960s.

- In recent years there has been an abdication of responsibility by the Federal government in regard to the health care of older and disabled Americans, and a corresponding shift of their health care costs onto private sector third party payers, especially employers and labor unions, and onto the Medicare beneficiaries themselves. The proposed legislation would represent a reversal of this unfortunate trend.

Protection under Medicare has been seriously eroded over the years as a result of cutbacks by the Federal government, plus incessant medical care inflation. For example, the Medicare Part A hospital deductible has risen from $40 at the inception of the program to $520 today.

The private insurance industry has not been able to provide adequate Medicare supplementary coverage at an affordable cost to millions of Medicare beneficiaries. Some 30 percent of the elderly and disabled have no insurance coverage supplementary to Medicare. Even for those who can afford "Medigap" policies, their return in benefits is appallingly low — some 60 cents in real benefits for every dollar of premium, compared to a return of 98 cents on the dollar under Medicare. And Medicare does not have pre-existing condition clauses, which deny benefits to many senior citizens under private insurance policies.

- Millions of Medicare beneficiaries and their families are forced to live in fear that financial catastrophe will accompany serious illness or injury. It is unconscionable that so many older Americans must suffer from such insecurity and anxiety after a lifetime of hard work and sacrifice.

## Proposed Measures

The Reagan Administration has taken a small, timid first step toward addressing these problems by endorsing the proposal put forward by Secretary Bowen. However, the $2,000 "stop-loss" limit on Part A and Part B expenses under the Administration's proposal would only benefit the small number of Medicare beneficiaries who have an extended hospital stay. According to the Health Care Finance Administration, only 0.53 percent of the 30 million Medicare beneficiaries, fewer than 160,000 individuals, use coinsurance days (61 to 90 days of hospital care) or lifetime reserve days (60 non-renewable days for stays beyond 90 days) in a given year. Thus, the proposal would provide only about one in 200 Medicare enrollees with any significant help. Many thousands of other beneficiaries on limited incomes would be bankrupt before reaching the $2,000 "stop-loss". In addition, since expenditures for prescription drugs, long term care, dental care and preventive health services are not counted toward this maximum, all Medicare beneficiaries would still face the threat of devastating catastrophic medical expenses. While a small step in the right direction, the modest improvements proposed in the Administration's plan provide little basis for Medicare beneficiaries and their families to sleep more peacefully at night.

The UAW urges Congress to enact a package of improvements in Medicare which contains the following elements:

- Removal of the limits on coverage for extended hospital stays;

- Elimination or drastic reduction of the $520 Part A deductible;

- Coverage of prescription drugs, especially maintenance drugs for chronic medical conditions, which alone can amount to annual costs of catastrophic proportions to many individuals;

- A much lower "stop-loss" than the $2,000 figure in the Administration proposal; and,

- Extension of the days of coverage and reduction of copayment amounts under the skilled nursing facilities benefit.

The UAW also calls upon the Congress to begin to assess and address the problem of inadequate services for and financial protection against long term disabilities. Medicare does not now cover such services, contrary to the mistaken belief of many citizens. The Administration proposal does not include it. We know that these problems are difficult, complex and costly. They are not amenable to a quick fix. But they must be faced and will require strong public action. The UAW urges the Congress to begin a serious assessment and to map out a plan of action to address these crucial needs.

Additional legislation is also required to combat the problem of "balance billing" by physicians treating Medicare beneficiaries. Charges by doctors beyond fees allowable under Medicare would not count toward the "stop-loss" limits under proposals by the Administration and others. Such overcharges amount to a serious flaw in the shield of protection against high out-of-pocket expenses. Measures to mandate or seriously strengthen assignment by physicians under Medicare need to be enacted in order to prevent dilution of the intended protection.

## Financing Issues

The issue of financing improvements in the Medicare program is of serious concern to the UAW, as it is for other labor and senior citizens' organizations and advocates for the disabled. The accumulated and prospective budget deficits, which represent one of the most enduring legacies of the Reagan Administration, greatly complicate the search for adequate and progressive financing. The UAW believes that sufficient revenues can be generated to pay for needed improvements in the Medicare program by taking a number of steps.

First, additional revenues can be realized by expanding Medicare coverage to include all employees of state and local governments. This is a long overdue step which would further the goal of making Medicare a truly universal program.

Second, additional savings can be achieved by recalculating the reimbursement rates for hospitals under the DRG reimbursement system. The recent study by the GAO suggests that the profit margins of many hospitals are sufficiently high to justify a "rebasing" of the DRG system.

Third, the UAW supports a premium-based financing system with a refundable income tax credit for low income beneficiaries, or some other provision to offset the cost to low income persons. We are willing to work with this Committee on the specifics of such a proposal. The principal point is to protect lower income elderly Americans, who too often now cannot afford both food and heat, from the hardship represented by even a relatively modest increase in the Medicare Part B premium. As a result of Administration initiatives, there have been large increases in Medicare premiums in recent years; it is time to reverse this trend by changing the existing basis for premium-sharing in the Medicare Part B program. A return to the prior-law standard under which Medicare Part B premium increases were linked to cost-of-living adjustments in Title II of the Act would provide substantial relief to all Medicare beneficiaries.

The UAW strongly opposes proposals to tax a portion of the actuarial value of Medicare benefits. This would establish an unfortunate precedent for taxing all health care benefits provided by employers to their workers and retirees. As you will recall, the UAW and other unions, as well as a broad segment of the business and insurance community, strenuously opposed such proposals when they were advanced by the Administration in the context of the tax reform legislation in the last Congress. We believe Congress made the right decision in rejecting such proposals at that time, and we see no reason to reverse that policy now.

Taxing Medicare benefits would also result in a substantial tax increase for a large portion of the elderly and younger disabled people and their families. The imposition of such a tax increase would be particularly unfair to those senior citizens and younger disabled workers who, in many cases, already receive protection against "catastrophic" medical expenses through insurance policies that are entirely paid for by their employer. This is the case for the vast majority of UAW retirees. The net result of such proposals to finance Medicare improvements by taxing the actuarial value of Medicare benefits would be to shift the cost of this protection from employers onto Medicare beneficiaries. We believe that this type of cost shift cannot be justified.

The UAW is concerned that the taxation of Medicare benefits would undermine support for the Medicare program. It is important to recognize the distinction between taxing cash income, such as Social Security benefits, and extracting taxes from individuals for in-kind services, such as health benefits, which only have some imputed actuarial value and do not represent any increase in cash income. In our judgment, there would be strong resistance among the elderly to the imposition of new taxes on Medicare benefits, since the beneficiaries are not receiving any cash income and may not even use the health care benefits in any given year.

The UAW also opposes any steps toward conversion of Medicare to a means-tested program. This does not mean that we would oppose certain forms of progressive financing, but maintenance of Medicare as a non-means-tested element of our social insurance fabric is essential.

Finally, the UAW asks this Committee and the Congress to recognize that millions of retired Americans, including the vast majority of UAW members, now have Medicare supplementary policies, paid for entirely by their former employers, which provide essentially the same or better protection as that which is proposed here today. The Administration plan, and other premium-based proposals, if not otherwise adjusted, would result in a windfall reduction in liability for many major corporations and a corresponding shift in cost, through the increased Part B premium, to Medicare beneficiaries. We trust that such an inequity could not be intended by the Congress. We urge inclusion of a "maintenance-of-effort" provision which would require employers to continue to contribute toward such coverage for a period of time, such as for the duration of existing collective bargaining agreements. We are prepared to work with this Committee on the specifics of such a provision to avoid unfair cost shifting from employers to Medicare beneficiaries.

## Summary and Conclusion

The UAW strongly supports enactment of improvements to Medicare to protect beneficiaries against catastrophic medical expenses. We urge this Committee to develop a legislative package which includes the following elements:

- a more meaningful benefit package to provide real protection, including prescription drugs, unlimited hospital stays and a lower "stop-loss" limit;

steps by Congress to address seriously the problem of meeting needs for long term care;

- further measures to end "balance billing" by physicians; and

- appropriate and equitable financing arrangements, including expansion of Medicare to cover all state and local government employees, rebasing of the DRG reimbursement system for hospitals, a premium-related method coupled with some form of assistance for low income beneficiaries, and "maintenance-of-effort" provisions where catastrophic protection is now provided for retirees by their former employers.

Even the enactment of such a package would do nothing to provide health care protection for some 35 million Americans who currently lack any health care coverage, most of whom are employed workers. It would do nothing to provide protection againt the cost of catastrophic illness for millions who are covered by inadequate insurance policies. These problems ultimately only will be resolved by the enactment of universal and comprehensive national health insurance.

The UAW would again like to thank this Committee for the opportunity to present our views on this important subject. We are anxious to work with the Members of the Committee in developing a package that will provide these much-needed improvements to the Medicare program.

Thank you.

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The **Chairman**. I have been listening to folks testify on this now for a while. As I listened this morning, there is no question but that you have made a compelling case that Medicare doesn't cover as much as we would like in the way of the costs for the elderly on health care, and that there are very substantial gaps in coverage. But as I look at this agenda and as I look at what we will probably receive from the Budget Committee, we may be in a position where we can only take care of the most pressing of those problems and gaps. It almost seems to me that the committee is in a no-win situation, that whatever is done is not enough.

If we get into that kind of a box, should we address what we can at this point, or just not have a catastrophic illness bill? Do you want to step up on that one? Mr. Seidman, you are leaning forward; let me hear it.

Mr. **Seidman**. We are in favor of any improvement that can be made. We do think that if you address only the question of catastrophic health insurance, improvements can be made as we have suggested on the proposal that has come forth from the Administration, which would make it easier for the elderly, who are already bearing a very substantial financial burden because of what Medicare does not cover, to pay for the additional coverage.

But we also think that you should give consideration beyond that to as much as possible to relieve that burden, and we have tried to indicate what we think are the priorities.

One priority is the one that both Mr. Killeen and I have referred to, and that is prescription drugs. And if you can't cover all prescription drugs, then the physicians know which are the ones that are the most important, and it is possible to develop that kind of a list. So, that is one area.

Another area is to make nursing home and home health care available to people, as a step toward the long-term care that we think is really needed that you were talking about with representatives of the insurance industry, at least for people who have had acute care episodes which have kept them in the hospital for a considerable period of time. The very restrictive provisions which now apply to them should be loosened up.

So, in other words, our feeling about this is that we think there are very, very serious needs which have to be addressed. We know that you will feel that there are restrictions and limitations on what you can do, and we have tried to indicate what we think our priorities are.

The **Chairman**. Well, let me ask another question. We have had several witnesses testify that Medicare beneficiaries really don't understand the limits of the coverage, and 70 percent believe that they have long-term health coverage. Now, what specific steps can we take to educate beneficiaries without unduly frightening them by telling them what the limitations are? What would you suggest?

Mr. **Killeen**. Mr. Chairman, if I may——

The **Chairman**. Yes, please.

Mr. **Killeen**. Perhaps we ought to frighten them a little bit. I am concerned about those who are complacent and who think that the Medicare program does cover long-term chronic disabilities. The Medicare program does not, and in our statement today we are not even asking you to include such coverage in this legislation this year; we were asking that the Congress address the issue and begin to develop some national plan to resolve the problem.

I think one of the reasons why there has not been——

The CHAIRMAN. What if there were an annual notification to the beneficiaries of what their coverage is and what the limitations are?

Mr. KILLEEN. That might be helpful.

Ms. SHEARER. Senator Bentsen?

The CHAIRMAN. Yes?

Ms. SHEARER. The Department of Health and Human Services has in the past prepared various educational materials which have been helpful in explaining coverage. One of the problems is, the more you stir up concern about coverage, the more you might drive people to load up on policies that we all know are not meeting the 60-percent loss loss ratio—many are much lower.

There is some information out, available, and perhaps increased mailings to consumers of the little brochure that HHS and the NAIC have put together would be helpful.

The CHAIRMAN. But the better they are informed, the better they can exercise their judgment, whether they make the right decision or not.

Ms. SHEARER. Well, one problem is that there is very little basis for deciding, for understanding, what is a good Medigap policy and what isn't. The consumer does not know if the policy they are considering is one that pays a loss ratio of 20 percent or one that pays 80 percent. That is one problem that the present system does not handle at all.

The CHAIRMAN. I see my time has expired.

Yes, Mr. Hungate?

Mr. HUNGATE. Could I make one brief comment?

The CHAIRMAN. You know, I think of some of the things that are sent out from the government are incredible. It is like the problems we had with the W-4 form. I read that thing five times before I finally thought I understood it.

Yes?

Mr. HUNGATE. You expressed the risk of a no-win situation. From my perspective, being able to pass a clear, crisp, catastrophic acute care cap on catastrophic expense would be a victory, if passed separate from all the other things that happen in Washington along toward the end of the year. If you can get it clearly done separately, it helps in making visible the other things that are not done. We as a company send an employee-benefits statement to each of our people at the end of every year that tells what they do have. We would welcome the addition of information to add with that that tells what is present in other areas.

The CHAIRMAN. Thank you. My time has expired.

Senator Packwood?

Senator PACKWOOD. Mr. Hungate, you would agree that for most people, average citizens in this country, if they do not have some kind of insurance coverage, that a catastrophic acute cost or long-term care cost is greater than they can probably afford?

Mr. HUNGATE. Yes, I do.

Senator PACKWOOD. Shouldn't we therefore be moving towards some form—for the moment I am not arguing public versus private, but some form—of coverage to alleviate that problem?

Mr. HUNGATE. For the acute catastrophic?

Senator PACKWOOD. And long-term care, as individuals on the average cannot afford either one, some form of coverage.

Mr. HUNGATE. I believe we should.

Senator PACKWOOD. To the extent we can, should we give a preference toward trying to solve that problem through private sector coverage?

Mr. HUNGATE. If I can separate the two for just a moment and say that, for the acute catastrophic care we have a defined, bounded financial number that we can deal with I think in the public or the private, I think public—given the pattern—would be an excellent way to go.

The long-term care is a much greater financial risk. I think there are many more uncertainties in that area currently. I would advocate more private sector solutions be presented, tried. We need more things starting there in order to find out what works and does not work, before we attempt to make a broader solution, which may evolve in time.

Senator PACKWOOD. Admitting that the need exists now for the long-term care, how does the private sector cover it? Give me ideas. If those people who are going to need the coverage, and it is going to be through insurance, will not purchase it until they are 55 or 56, or until they think they see the need, could they afford the premiums?

Mr. HUNGATE. The concepts that I hear talked about relate to the ideas of making some kind of a life insurance package that might convert to a long-term care package at some time when life insurance is less critical than long-term care coverage. There are other approaches to look at existing retirement plans. For instance, in our plan we have the option of being in a stock fund or a bond fund, in terms of the vested portion of our plan. There may be ways to feather in a long-term care from within that retirement package. It is an issue that faces people in retirement. We need to address it in that context, at least as far as we are concerned in looking at the welfare of our employees.

Senator PACKWOOD. What do you do with the people either who work for employers who don't cover long-term care coverage on retirement or they just don't buy the policy? They don't provide for their own coverage, and then they are 70 years old, and they need it, and they don't have it.

Mr. HUNGATE. I think making the value of that coverage very visible is helpful in the competitive market of companies who are hiring people. Companies need to be able to differentiate "why you should work for me instead of working for someone else." A benefit program is often a differentiator. To dictate that as a common basis, move some of the flow out of the marketplace that improves the long-term coverage, mandating a directed benefit in that case destroys some of the lifeblood of that process in the mobility of the workforce. Is that an adequate answer to the question?

Senator PACKWOOD. I understand your answer. I am not sure that mandated benefits always do not work. We by and large mandate workers compensation—relatively little at the federal level, it is mostly state. But we simply say to your company, if an employee loses an arm they get X-amount of money, "Now, you go out and purchase from Aetna, or maybe California has a public system also, and you have your choice." The system doesn't work all that badly, but it is mandated coverage.

Mr. HUNGATE. Workmens Comp does fall in that category. It has had problems here and there that need to be corrected and have been corrected, but it has worked relatively well.

Senator PACKWOOD. Why not then just mandate the health coverage, and then say to you, "Now, you go out and purchase the coverage where you want, at the most competitive price in the best fashion you think, but this is the following coverage you have to have," and we list it, including catastrophic costs?

Mr. HUNGATE. There is a difference between mandating something where the answer is clear in terms of what the competitive impact is and how that will work out in the long-term pattern, and where there is great uncertainty in what it is that we are dealing with. The costs of long-term care are not well described. To include that in such a package would leave great uncertainty and be a competitiveness issue that many of us have great concern about.

Senator PACKWOOD. One of two things will happen, assuming the insurance companies will try to cover it, that they will try to figure out what the cost is and sell you a package. Either they will tremendously overprice it to cover any risks they don't forsee, or they will tremendously underprice it because it is competitive, and when they are on the verge of bankruptcy because of the policies they will come to the Federal Government for a bail-out, or raise your premiums immensely on very short notice. I think that is partially what has happened in product liabilities, that the policies were underpriced for some period of time.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Heinz?

Senator HEINZ. Mr. Chairman, thank you.

Mr. Seidman, I share your concern about the low-income elderly, and now in your testimony you recommended a refundable tax credit to offset the additional cost of a catastrophic premium for those up to 150 percent of poverty. How would such a credit work for those elderly—and there are several million of them—who do not have adequate income to file an income tax return?

Mr. SEIDMAN. It would work the same as the earned-income tax credit does for poor people who are working.

Senator HEINZ. But they have to file a tax return. The tax reform bill, for example, took one million elderly right off the tax rolls.

Mr. SEIDMAN. And I would think these people would have to file a tax return, and they would have a great incentive to do so if they knew they were going to have a refundable tax credit.

Senator HEINZ. But you would have it work like the earned-income tax credit?

Mr. SEIDMAN. Yes.

Senator HEINZ. You also said in your testimony that you oppose the Stark-Gradison funding mechanism, and I think I heard somebody else echo that same position. What would be your position on a supplemental premium that is paid through the income tax system, as was suggested by I think it was Ms. Lehnhard in the previous panel? It was a kind of scaled surtax, as I recollect.

Mr. SEIDMAN. This would, in effect, be the reverse of the earned-income tax credit, is that right? I mean, in other words, that people who were of low income would not pay the premium, and people of higher income would?

Senator HEINZ. It wouldn't be the reverse; it would be a surtax on people who pay taxes. You would go to another tax table, and there would be some kind of appropriate adjustment based on ability to pay.

Mr. SEIDMAN. Well, in the first place, we think this would add a complexity to the system; but second, we think it would open the door to income-testing the Medicare program, and generally we have been opposed to that.

Senator HEINZ. All right. Thank you.

Mr. Hungate, let me ask: Do you think employers would be much more willing to provide health insurance coverage for their retirees if they could be assured that their liability would terminate when those retirees reached age 65 and therefore became eligible for Medicare and employers didn't have to be first-party payors?

Mr. HUNGATE. I have to be careful of the statistics here, but most of us do continue to provide health care benefits post-retirement, even in the presence of Medicare. So, most will not change that practice, I believe.

Senator HEINZ. All right. You made a point somewhere along the line that when we enacted the 1982 changes, the Medicare working-aged provisions, that the number of senior citizens employed dropped. What are your subsequent statistics? I should note that the employment of all kinds of people dropped in 1982 and 1983. What has happened since then?

Mr. HUNGATE. Our employment has flattened considerably since 1982 and 1983.

Senator HEINZ. Have more elderly people been employed and covered?

Mr. HUNGATE. We have two groups. Many are leaving at age 55, and many are staying to 70. People tend to separate in terms of their personal choices. Most of those who stay on after 65 take up the Medicare coverage at the time they pass 65, but we stay as the primary payor under that, and then go on to retirement at a later time. I can't give you exact percentages or distributions on that.

Senator HEINZ. How do you recommend that we expand access to health insurance for the 37 million Americans who don't have any coverage at all?

Mr. HUNGATE. Currently in Massachusetts we have quite a problem of uncompensated care. I spend a major amount of my time there. We are working aggressively to build a program there that covers that part of the population. I believe that there are different situations from state to state. It is a problem that needs to be solved, and state-level solutions should be encouraged.

Senator HEINZ. Well, we will just leave it up to the states to handle that one?

Mr. HUNGATE. I think I would keep talking and pushing, but I think the states recognize that the problem needs solving and are addressing it, and businesses are addressing the backing of that at state levels.

Senator HEINZ. Do you think they can address catastrophic coverage and long-term care?

Mr. HUNGATE. I would not broaden that to the long-term care issue as a state issue. I think you are addressing, basically, the uncovered, below 65, which shows up currently largely in uncompensated care at hospitals. It shows up in provider organizations. I think there is a way to address with state-level—which vary by state.

Senator HEINZ. I think we would be interested in seeing specifically what that way is, but my time has expired.

The CHAIRMAN. Thank you very much. Your testimony has been helpful and the level of expertise shown on the panel will certainly help us in our deliberations.

Thank you.

Our next panel will be Rosemary Marcuss, who is the Assistant Director for Tax Analysis, Congressional Budget Office; Lynn Etheredge, Consolidated Consulting Group; and Ronald F. Pollack, Executive Director of Villers Advocacy Associates. Would you please come forward?

Dr. Marcuss, if you would proceed, please.

## STATEMENT OF ROSEMARY MARCUSS, PH.D., ASSISTANT DIRECTOR FOR TAX ANALYSIS, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Dr. MARCUSS. Thank you, Mr. Chairman.

I am pleased to appear before the committee today to discuss options for financing new Medicare benefits. I would like to introduce Steve Long and Rick Kasten from CBO who are sitting on my left. I would also like to ask that my written statement be included in the record.

The CHAIRMAN. That will be done.

Dr. MARCUSS. Thank you.

I will briefly summarize my remarks, which cover three subjects: Issues that must be resolved in financing new catastrophic benefits under Medicare, some already mentioned; illustrative financing options and their revenue potential; and relative burdens of payments under these alternatives for families at different income levels.

Table 1 on page 2 of my remarks shows CBO's baseline projection of the sources of income for the Medicare Trust Funds in 1988. As you can see, 8 percent of Medicare receipts come from current enrollees; 92 percent come from general taxpayers and wage earners.

The choice among sources of revenue to finance benefits raises several basic issues: Who should pay? How should the payments be collected? How can unintended side effects be kept to a minimum?

In considering who should pay, the Congress must first determine both the mix of payments from general taxpayers and current program beneficiaries and how the payments might be related to the incomes of those who pay. Raising any given amount of revenue from many taxpayers, of course, leads to a lower incremental contribution per person. Among broad-based tax sources increased payroll taxes could be viewed as a contribution by workers towards their own future benefits.

On the other hand, the choice of raising Trust Fund revenues by increasing payments of current enrollees would place the responsibility squarely on those who would benefit directly from increased Medicare coverage. Because many enrollees have Medigap policies, their additional contribution could be offset by savings on their private insurance premiums; since, these policies would be modified to reflect the expansion of the benefits under Medicare. Moreover, the elderly may be seen to be capable of financing a modest increase in benefits, because their income has risen relative to the income of the non-elderly over recent years.

On the issue of who should pay, the choices before the Congress concern not only the relative contribution of general taxpayers and current enrollees, but also whether or not payments should be based on the taxpayer's ability to pay. For example, if the new benefits were to be financed by the payroll tax, the tax increase might be distributed in proportion to current payroll taxes, or it might be targeted toward those with the highest wages who currently pay taxes on only part of their earnings.

Similarly, if additional payments were limited to current enrollees, the Medicare premium might be increased for all enrollees or, alternatively, payments might be related to income.

The choice of financing mechanisms also raises the issue of administrative feasibility and cost. If additional payments are to come from genenal taxpayers, a number of revenue sources—the payroll tax, the personal income tax, and selected excise taxes—could be increased with relatively low administrative costs.

If the Congress wishes to increase enrollee payments in a way that is related to the income of the enrollee, it couldn't use the SMI premium—the only present source of payments from the enrollees—as a vehicle, because the Medicare program doesn't collect information on income as part of its eligibility process. Financing options that take advantage of income data already collected by the Social Security Administration and the Internal Revenue Service would be more feasible administratively.

An important consideration in choosing financing mechanisms is to minimize side effects. For example, if the expanded Medicare benefits were to be funded solely through higher premiums based on enrollee income, the payments required of high-income enrollees could exceed the value of their Medicare benefits. Payments of this magnitude could represent an unfair burden to those enrollees. Some enrollees, when faced by this prospect, some might in fact drop out of Medicare and seek private insurance or go without insurance. To keep this unintended effect to a minimum, the income related payment per enrollee could be limited—for example, to an amount that would be less than the insurance value of the Medicare benefits.

The **Chairman**. Dr. Marcuss, if you would, summarize, please.

Dr. **Marcuss**. If you would turn to Table 2, I will just show you the options that we present. We show two payroll tax options—increasing the HI payroll tax rate, and eliminating the maximum on taxable earnings.

We also look at four options that affect current Medicare enrollees only—a premium on all enrollees, a fee based on the level of Social Security benefits, a surcharge on taxable income, and the inclusion of a portion of the actuarial value or average benefit of Medicare in adjusted gross income of enrollees.

If you would turn to Figure 2, I can just show you what we present here in the way of distributional effects.

The **Chairman**. All right.

Dr. **Marcuss**. If you look at panels A and B in Figure 2, which is on page 16, premiums and fees related to Social Security benefits generally would not vary with income, and they would be paid by about 90 percent of enrollees.

If you look at panels C and D, the two approaches based on the income tax—affecting about one-half of enrollees—would leave enrollees with the lowest income unaffected, but would collect increasing amounts as incomes rise to levels at which the maximum tax would be reached.

In looking at these illustrations, it is important to keep in mind that 54 percent of current enrollees have incomes below $20,000 and only 11 percent have incomes above $50,000.

I will stop here in the interest of time. I would be happy to answer any more questions on the specific options which we show.

I would like to add, however, that the Congress may well choose to use a combination of options, so that they would come up with a different effect across families of different income levels.

The **Chairman**. Well, this will be very helpful to us. Obviously it will take some time to study it.

Thank you.

Mr. Etheredge, if you would proceed, please.

[Dr. Marcuss's written prepared testimony follows:]

Statement of
Rosemary D. Marcuss
Assistant Director
Tax Analysis Division
Congressional Budget Office

before the
Committee on Finance
United States Senate

March 26, 1987

NOTICE
This statement is not available for public release until it is delivered at 10 a.m. (EST) on Thursday, March 26, 1987.

The Congress is considering proposals that would expand Medicare coverage and set a maximum on the amount that an enrollee could spend out-of-pocket for health services covered by the program. Most proposals would also provide for new trust fund revenues that would offset the added program outlays.

At your request, my remarks are limited to the financing of catastrophic insurance benefits under Medicare. After outlining the way Medicare is currently financed, this statement focuses on three topics:

- The issues that must be resolved in financing new benefits,
- Some illustrative financing options and their revenue potential, and
- The relative burden of payments under these alternatives for families at different income levels.

## BACKGROUND

Established in 1965, Medicare will insure about 29 million elderly and 3 million disabled Americans in 1988. The Hospital Insurance (HI) portion of Medicare--which provides inpatient hospital, skilled nursing, and home health services--is financed largely from payroll taxes, currently set at 1.45 percent of covered wages from both employers and employees. The Supplementary Medical Insurance (SMI) portion--which provides physician, hospital outpatient, laboratory, and other services--is financed largely by federal general revenues and enrollee premiums, currently set at $17.90 per month. Only 8 percent of Medicare receipts come from current enrollees, while 92 percent come from general taxpayers and wage earners, as shown in Table 1.

TABLE 1. SOURCES OF INCOME FOR THE MEDICARE TRUST FUNDS, FISCAL YEAR 1988

| | Income | |
|---|---|---|
| Trust Fund/Income Source | Billions of dollars | Percent of total |
| Total | 101.4 | 100 |
| Hospital Insurance | | |
| Payroll taxes | 61.7 | 61 |
| Interest | 4.6 | 5 |
| Other | 0.9 | 1 |
| Supplementary Medical Insurance | | |
| Enrollee premiums | 8.0 | 8 |
| Transfers from general revenues | 25.4 | 25 |
| Interest | 0.8 | 1 |

SOURCE: Congressional Budget Office baseline for fiscal year 1988.

Medicare leaves "gaps" in its coverage of hospital and physician services, including deductibles, coinsurance, and limits on covered hospital days. To protect against large out-of-pocket costs that might arise because of these gaps, a market in private supplementary insurance--"medigap" policies--has developed. Like all private insurance, the premiums paid for these policies finance both health care benefits and the marketing and administrative costs of the insurance; the nonmedical portion of the cost typically ranges from 15 percent to 35 percent of the premium paid by the elderly. Medigap insurance covered about 45 percent of the elderly in 1967. By 1984, more than 70 percent of the elderly had medigap coverage. Medicaid fills the same gaps in coverage for an additional 10 percent of low-income elderly, making almost 80 percent of the elderly covered for such costs.

About 20 percent of the elderly, or about 6 million enrollees, have no supplementary coverage to protect them against high out-of-pocket expenses for services covered by Medicare. These people--who tend to be older, in poorer health, and of lower income than those with medigap insurance--may be of particular concern to the Congress as it considers changes in Medicare's benefits to provide coverage against catastrophic expenses.

## ISSUES IN FINANCING NEW MEDICARE BENEFITS

If the Congress decides to expand Medicare benefits to provide coverage against catastrophic expenses, it could choose among a range of sources of additional trust fund revenue to finance the added outlays. The choice among sources of revenue raises several issues:

- Who should pay?
- How should these payments be collected? and
- How can unintended side effects be kept to a minimum?

### Who Should Pay?

In considering who should pay, the Congress must first determine both the mix of payments from general taxpayers and current program beneficiaries and how payments might be related to the incomes of those who pay. Raising a given amount of revenue from many taxpayers would lead to a lower incremental contribution per person. Furthermore, increased payroll taxes could be viewed as a contribution by workers toward their own future benefits.

On the other hand, raising trust fund revenues by increasing payments of current enrollees would place the responsibility on those who would benefit directly from the increased Medicare coverage. Because many enrollees have medigap policies, their additional contributions would be offset by savings on their private insurance premiums, since those policies would be modified to reflect the expansion of benefits under Medicare. Moreover, the elderly may be capable of financing a modest increase in benefits, since their income over the last two decades has risen relative to the income of the nonelderly.

The issues before the Congress concern not only the relative contributions of general taxpayers and current enrollees, but also whether or not payments should be based on ability to pay. For example, if the new benefits were financed by the payroll tax, the increase might be distributed in proportion to current payroll taxes, or it might be targeted toward those with the highest wages who currently pay taxes on only part of their earnings. Although an increase in the payroll tax rate would spread the cost of expanded coverage over all 75 million families with earnings, workers already face a payroll tax increase next January. Eliminating the maximum on taxable earnings subject to the payroll tax ($45,300 in 1988) would limit the tax increase to families with the greatest ability to pay but would place a large burden on these families.

Similarly, if additional payments are limited to current enrollees, the Medicare premium might be increased for all enrollees or, alternatively, payments might be related to income. Raising the premium for all enrollees would be consistent with the view that since benefits do not vary systematically by income, neither should payments. On the other hand, equal per capita payments would collect a larger share of income from low-income enrollees than from those with higher incomes. Furthermore, since benefits to the average current Medicare enrollee far exceed the value of past contributions, some observers argue that the subsidy to higher-income enrollees is already too great relative to their ability to pay.

## How Should these Payments be Collected?

The choice of financing mechanisms also raises issues of administrative feasibility and cost. If additional payments are to come from general taxpayers, a number of current revenue sources--including the payroll tax, the personal income tax, and selective excise taxes--could be increased or altered with relatively minor administrative costs. These tax sources offer a range of options in relating payments to ability to pay.

At present, the only source of payments from Medicare enrollees is the SMI premium. If the Congress wishes to increase enrollee payments in a way that is related to the income of the enrollee, it could not use the SMI premium as a vehicle because the Medicare program does not collect information on income as part of its eligibility process. Establishing a system for collecting and verifying income data for 32 million enrollees would be very costly.

Options that take advantage of income data already collected by the Social Security Administration and the Internal Revenue Service (IRS), would be more feasible administratively. The drawbacks to these two sources are that they use an incomplete definition of income and, especially in the case of IRS data, exclude many Medicare enrollees. About half of Medicare enrollees do not file tax returns--for the most part, because Social Security benefits are not taxable for most recipients. In 1988, individuals with less than $5,900 and couples with less than $10,100 in income from taxable sources will owe no income taxes regardless of the size of their Social Security benefits.

### How Can Unintended Side Effects be Kept to a Minimum?

A final issue in choosing financing mechanisms is to minimize side effects. For example, if the expanded Medicare benefits were to be financed solely through higher premiums based on enrollee income, the payments required of high-income enrollees could exceed the value of their Medicare benefits. Payments of this magnitude could represent an unfair burden to these enrollees. Some current enrollees, when faced by this prospect, might in fact drop out of Medicare and either seek private insurance or go without insurance. To keep this unintended effect to a minimum, the income-related payment per enrollee could be limited--for example, to an amount that would be less than the insurance value of Medicare benefits.

## SOME ILLUSTRATIVE FINANCING OPTIONS

The Congressional Budget Office's (CBO's) preliminary estimate of the benefits under the catastrophic insurance plan proposed by Department of Health and Human Services Secretary Bowen is about $2 billion in 1988. Other proposals would involve considerably greater benefits. The remainder of my statement will illustrate a range of financing options by discussing two alternatives for increasing payroll taxes and four alternatives that would affect only current enrollees. Table 2 gives a brief description of each option and shows approximately how much revenue it could raise. An expansion of Medicare benefits could be financed with these or other options, used alone or in combination. Some of the options do not raise enough revenue to finance current proposals on their own. A combination of options may be necessary to achieve a desired mix of financing between all taxpayers and current enrollees, or between enrollees of different income levels. The revenue amounts in the table do not represent official budget estimates for any specific proposal. The income tax estimates are calendar year tax liabilities.

CBO has examined two means of increasing payroll taxes. One would be to raise the current Hospital Insurance payroll tax rate by 0.10 percent--from 1.45 percent to 1.55 percent--for both the employee and the employer. This increase would add $3.9 billion in revenue for 1988. An alternative would be to raise the maximum amount of wages on which the HI portion of the payroll tax must be paid. In 1988, the taxable maximum is projected to be $45,300. Eliminating the cap (that is, making total wage, salary, or self-employment income for each worker taxable) would yield about $5.6 billion in revenue in 1988.

TABLE 2. EXAMPLES OF FINANCING SOURCES AND THEIR REVENUE POTENTIAL, 1988 a/

| Financing Source | Approximate Revenue Potential (In billions of dollars) |
|---|---|
| **Payroll Tax Options** | |
| Increase the Hospital Insurance Payroll Tax Rate from 1.45 Percent to 1.55 Percent | 3.9 |
| Eliminate the Maximum on Taxable Earnings ($45,300 in 1988) for Calculating the Hospital Insurance Payroll Tax | 5.6 |
| **Options that Affect Current Medicare Enrollees Only** | |
| Impose a Premium on All Current Enrollees | |
| $5 per month | 1.8 |
| $10 per month | 3.6 |
| Impose a Fee Based on the Level of Social Security Benefits | |
| 1 percent of benefits | 1.6 |
| 2 percent of benefits | 3.3 |
| Impose a Surcharge on the Taxable Income of All Current Enrollees | |
| 1 percent up to the value of new benefits b/ | 0.9 |
| 2 percent up to the value of new benefits b/ | 1.1 |
| 5 percent up to the value of new benefits b/ | 1.2 |
| 1 percent up to the SMI subsidy value c/ | 1.9 |
| 2 percent up to the SMI subsidy value c/ | 3.4 |
| 5 percent up to the SMI subsidy value c/ | 6.1 |
| Include a Portion of the Actuarial Value of Medicare in Adjusted Gross Income d/ | |
| Include 50 percent of the actuarial value of HI | 2.4 |
| Include 75 percent of the actuarial value of SMI | 2.2 |
| Include 50 percent of the actuarial value of HI and 75 percent of the actuarial value of SMI | 4.8 |

SOURCE: Preliminary Congressional Budget Office estimates.

a. Calendar year; assumes full implementation on January 1, 1988.

b. Assumes that new benefits average $100 per enrollee.

c. The SMI subsidy value--that is, the value of SMI benefits in excess of premiums paid--is projected to be $845 per enrollee in 1988.

d. The actuarial value of Medicare benefits is defined as total benefit payments divided by total enrollees--that is, average benefits.

The remaining options would affect only current Medicare enrollees. The first alternative would be to impose a premium on all current enrollees. A premium increase of $5 per month would net the government $1.8 billion in 1988. An increase of $10 would raise twice as much.

One way to base payments on income might be to use Social Security benefits to represent ability to pay. Supplementary Medical Insurance premiums are now collected by the Social Security Administration, so it would be feasible to collect a fee based on the level of Social Security benefits. If all Medicare enrollees were charged a fee equal to 2 percent of their Social Security benefits, about $3 billion would be raised.

Alternatively, income-related options could use the individual income tax system to raise additional revenue from current Medicare enrollees. One set of options would apply a surcharge to their taxable income. The first of these options would impose a surcharge of 1 percent of taxable income, but would limit each enrollee's liability to the average cost of the new benefits. If the new Medicare benefits cost $100 per year for each beneficiary, this option would generate about $1 billion of the $3 billion total cost. Raising the surcharge rate above 1 percent would bring in relatively little additional revenue, because many taxpayers would pay the maximum $100 surcharge with even a 1 percent tax. By design, no beneficiary would pay more than his or her share of the costs, and many beneficiaries would pay nothing because their taxable income would be too low. Consequently, these options would have to be combined with some additional revenue sources in order to be self-financing.

The other surcharge options would allow the surcharge paid by an individual to be as high as the total subsidy value of SMI. For current enrollees with high incomes, these surcharges would result in payments that exceed their new benefits. In 1988, the subsidy value under current law would be $845. Revenues would increase by $1.9 billion with a 1 percent surcharge. A 5 percent surcharge would generate about $6.1 billion. 1/

The final set of options would require Medicare enrollees to include part of the actuarial value of their benefits in adjusted gross income (AGI) for purposes of the individual income tax. Including 50 percent of the

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1. The maximum tax could be raised to include part of the actuarial value of the Hospital Insurance portion of Medicare. For example, including half of HI would add an additional $0.1 billion with a 1 percent surcharge, $0.4 billion with a 2 percent surcharge, and $2.0 billion with a 5 percent surcharge.

actuarial value of Hospital Insurance benefits provided under current law would generate about $2.4 billion in 1988. Including 75 percent of the current law value of SMI benefits would generate about $2.2 billion. 2/Revenue would increase by $4.8 billion if both parts of Medicare were made partially taxable. 3/ Revenues from these options would be somewhat higher if the value of new benefits were made taxable also.

## DISTRIBUTION OF PAYMENTS BY FAMILY INCOME

The illustrative options presented here would collect different amounts from people at different income levels. Figures 1 and 2 show the probable patterns of average annual payments by family income level for options affecting wage earners and for options affecting current enrollees, respectively. Family income is the total annual cash income (including realized capital gains) for all related persons living in the same household.

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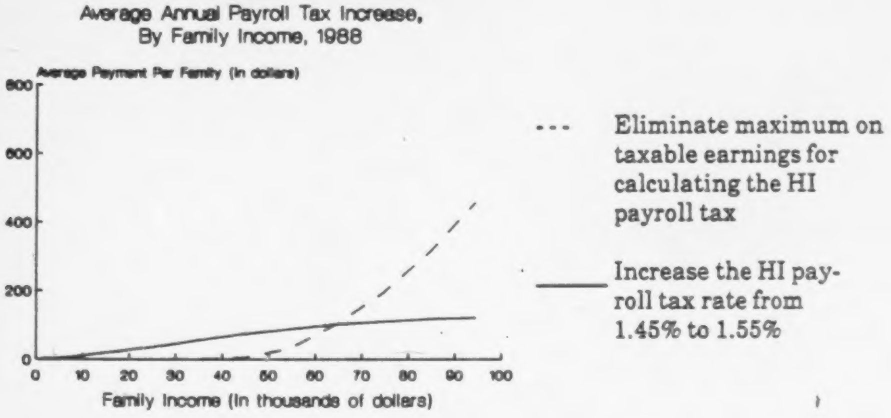
2. It is sometimes argued that Medicare's HI benefits are 50 percent earned as a result of an enrollee's past payroll tax contributions and 50 percent subsidized through past employer payments. Medicare's SMI benefits are partly financed by current enrollee premiums, which represent about 25 percent of program costs, and are 75 percent subsidized by transfers from general revenues.

3. The inclusion of both HI and SMI would raise more revenue than the sum of their separate yields, because any expansion of adjusted gross income moves families onto the tax rolls and into higher tax brackets.

## FIGURE 1. AVERAGE ANNUAL PAYROLL TAX PAYMENT, BY FAMILY INCOME, 1988

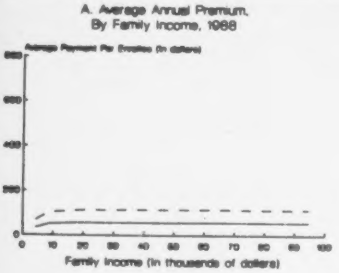


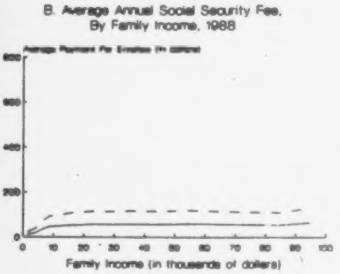
SOURCE: Preliminary Congressional Budget Office estimates.

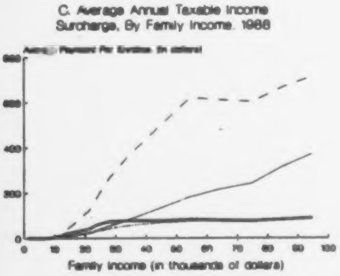
Figure 1 compares two payroll tax options that would affect wage earners. A small increase in the current tax--represented by the solid line--would cost an average of nearly $60 per family (one-half from employees and one-half from employers) for about 75 million families. Although in 1988 each worker will stop paying payroll taxes when his or her earnings reach $45,300, average payments would continue to rise for families with incomes above that level because many of those families earn less than the ceiling. Also, families with more than one worker would, in effect, face a higher ceiling. In contrast, the elimination of the taxable earnings ceiling--represented by the broken line--would leave all of the nearly 80 percent of families with incomes below $45,300 unaffected, but would collect rapidly growing amounts from families at incomes above that level. The average payment per family among all those families paying the new taxes would be $800 per year; among those with incomes above $100,000, it would be $1,700 per year.

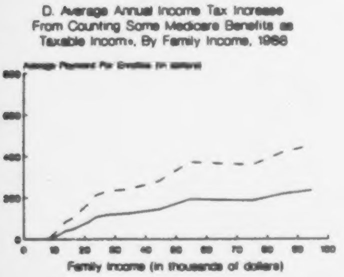
Figure 2 shows the same type of information for financing options that would affect only current enrollees. Each panel represents one of the four generic options--premiums, fees on Social Security benefits, surcharges on enrollees' taxable income, and making some Medicare benefits subject to income taxation--while the different lines in each panel display the effects of variants on these options. The lines represent average increases in payments for current enrollees, including those whose increase is zero. The average increase for enrollees who do pay more may be much higher than the average payment shown here.

**FIGURE 2: ILLUSTRATIVE PAYMENTS FROM CURRENT MEDICARE ENROLLEES**


A. Average Annual Premium, By Family Income, 1988


B. Average Annual Social Security Fee, By Family Income, 1988


C. Average Annual Taxable Income Surcharge, By Family Income, 1988


D. Average Annual Income Tax Increase From Counting Some Medicare Benefits as Taxable Income, By Family Income, 1988

| | Option | Percent of Enrollees Affected | Average Payment Per Enrollee |
|---|---|---|---|
| - - - | $10 per month premium | 88 | 106 |
| — | $5 per month premium | 88 | 53 |
| - - - | 2% fee on Social Security benefit | 86 | 101 |
| — | 1% fee on Social Security benefit | 86 | 55 |
| - - - | 5% surcharge up to subsidy value of total SMI benefit | 45 | 192 |
| — | 1% surcharge up to subsidy value of total SMI benefit | 45 | 60 |
| ━ | 5% surcharge up to subsidy value of new benefits | 45 | 40 |
| ... | 1% surcharge up to subsidy value of new benefits | 45 | 28 |
| - - - | Include 50% of actuarial value of HI and 75% of SMI in AGI | 52 | 152 |
| — | Include 50% of actuarial value of HI in AGI | 48 | 76 |

SOURCE: Preliminary Congressional Budget Office estimates.

Premiums and fees related to Social Security benefits generally would not vary with income (see Panels A and B in Figure 2). The two approaches based on the income tax would leave enrollees with the lowest income unaffected but would collect increasing amounts as income rises to levels at which the maximum tax would be reached (see Panels C and D). In looking at these illustrations, it is important to keep in mind that 54 percent of current enrollees have incomes below $20,000 and only 11 percent have incomes of $50,000 or more.

Panel A of Figure 2 shows the effect of two possible premium increases by level of income. Because Medicaid pays the premium for many enrollees at low levels of income, the average payment is low. At levels of income above $15,000, most enrollees would pay their own premiums, with little variation in the average payment.

Panel B shows the effect of two possible options in which the payment would be a fraction of an enrollee's Social Security benefit. The pattern of payments is quite similar to that in Panel A, but the average payments for the Social Security options are somewhat lower for families with incomes below $10,000.

Panel C shows the effect of four possible surcharges on taxable income. Most families with incomes below $10,000 would be unaffected by all of these options because they have no taxable income. The bottom two curves represent surcharges capped at the subsidy value of new benefits--$100 in this example. Average payments with a 5 percent surcharge rise faster than average payments with a 1 percent surcharge, but the two payments merge at about the $50,000 income level, where most enrollees would pay the maximum surcharge at either tax rate.

The top two curves in Panel C represent surcharges that can be as high as $845 per enrollee. Again, payments with a 5 percent surcharge rise faster than the 1 percent surcharge. Average payments from a 5 percent surcharge with an $845 cap quickly rise above average payments with a $100 cap, because only $2,000 of taxable income is necessary to hit a $100 maximum tax with a 5 percent tax rate. Average payments for both 1 percent surcharges are the same up to family income of about $20,000.

The final panel represents the effect of including the actuarial value of Medicare in adjusted gross income. These options affect enrollees at somewhat lower levels of income than the surcharge options because some enrollees who have no taxable income under current law would owe taxes under these options. Although these tax options show a stronger relationship between average payments and family income than some other options, there is a good deal of variation in actual payments at each family income level. The variation arises because families with the same total income may have quite different amounts of taxable income.

## CONCLUSION

If the Congress chooses to expand Medicare benefits to reduce the risk of catastrophic out-of-pocket costs, it must resolve many issues when selecting from among alternative sources of financing for these benefits. The most general choice involves how the additional payments would be divided among general taxpayers, wage earners, and current enrollees. In addition, there is a choice of whether or not payments should be related to ability to pay. The options analyzed separately here provide a range of possible resolutions of these issues. Moreover, a financing package that would depend on a mix of options could provide distributions of total payments that would fall within the range of those shown here.

## STATEMENT OF LYNN ETHEREDGE, CONSOLIDATED CONSULTING GROUP, WASHINGTON, DC

Mr. **ETHEREDGE.** Thank you, Mr. Chairman.

My written testimony deals with two major financing issues with which this committee is concerned. The first is how to finance improved catastrophic medical insurance benefits, and the second is how to build a much larger financial base which Medicare is going to need to assure current benefits and long-term care coverage well into the next century.

At the risk of simplifying very complex issues, I will summarize several key points.

For financing catastrophic medical insurance benefits, the two most frequently mentioned sources are those that would increase the 8 percent share of Medicare financing which is now borne by enrollees: either across-the-board premiums like the SMI premium or income tax financing.

Both of these approaches have advantages and disadvantages. The advantages of premium financing are that the premiums that we are discussing—$5 to $15 a month—are affordable by most of the elderly who are already paying for such premiums in Medigap policies. They are also equitable, because most of the elderly can afford those policies and have after-tax incomes per capita that are slightly better than the under-65 population.

But there are disadvantages to premium financing. The major one is the lack of good coverage under Medicaid for the low-income elderly. Only about 36 percent of low-income elderly below the poverty line now have Medicaid. So that means that out-of-pocket expenses already are very high for many of the elderly living in poverty. Adding more premiums for them would just increase their burdens. Five dollars a month might be manageable, but I think at a $15 a month reduction in their Social Security benefits, which is the way in which mechanically this would work, one has to worry about added burdens.

The second basic strategy is income tax financing. Again, advantages and disadvantages. The advantages are that it relates the financing to ability to pay. It would improve the general equity of the tax system if it included some of the actuarial value of HI and SMI in the available income of the elderly.

But there are disadvantages also to the tax system. The major one is that it is somewhat unfair to the high-income elderly. Because most Social Security benefits are not counted as taxable income, only about half of the elderly have any income tax burden. And that means that if catastrophic benefits were financed entirely by income tax financing, the full cost for the 28 million elderly would fall on roughly 45 or 50 percent of the aged population, who are obviously going to have to be paying roughly twice or more what they themselves would receive.

In summary, I think the committee can look to both premium and income tax financing mechanisms to finance catastrophic benefits, but both of them could be made more equitable. To complement premium financing, for example, Medicaid could be improved to help reduce the burden on the low-income elderly. And to make income tax financing somewhat more equitable, more Social Security benefits could be included in adjusted gross income so that the burden would be shared more broadly among the middle class of elderly and not just the high-income.

With that combination of improved Medicaid for the low income, premium financing by all the elderly, and some income tax financing, I think the committee could distribute the burden of Medicare catastrophic within the elderly population to achieve virtually any distribution that you thought was desirable.

Going beyond basic Medicare catastrophic costs—the $5 to $15 a month—this committee has already started to consider the expenses that are going to be involved with financing long-term care, and ultimately the whole cost of retirement of the baby-boom generation.

Here, let me suggest that the committee, in addition to the current array of taxes that have been suggested, also may want to consider estate tax reforms as a well-justified way of helping to protect the elderly's assets by providing them insurance. It seems to me that would be a productive and a now virtually untapped resource.

The CHAIRMAN. Would you restate that so I can better understand your point?

Mr. ETHEREDGE. All right. I am suggesting a consideration of estate tax reforms, taxing the values of the elderly's estates as they pass on to the next generation.

As of 1984, the Census Bureau reported the net worth of the elderly was about $2 trillion. That is a median net worth of about $60,000 per household. Most of that now escapes taxation because of the exclusion of $600,000 from estate taxes; so only about $6 billion is raised from that source. Now, that net worth of today's elderly, of course, is going to grow for future generations as they inherit the assets of the prior generation. So I would suggest that estate taxes are one of the major financing sources, together with premiums and income taxes, to which this committee could look to finance the types of protections of income and protection of estates that we have been discussing this morning.

Thank you.

The CHAIRMAN. Mr. Pollack, would you proceed?

[Mr. Etheredge's written prepared testimony and answers to Senator Mitchell's questions follow:]

# TESTIMONY OF MR. LYNN ETHEREDGE
# BEFORE THE SENATE FINANCE COMMITTEE
# MARCH 26, 1987

Mr. Chairman and Members of the Committee:

I appreciate the invitation to testify before you this morning on the subject of financing the Medicare program and improved catastrophic insurance benefits.

My background includes serving as a Medicare program analyst with the Office of Management and Budget from 1971-1976 and as director of its professional health staff from 1978-1982. Since leaving government, my research and other activities have continued to deal mostly with issues of financing health services and long term care for the nation's elderly population. I am appearing today as an independent health policy consultant.

There are two basic Medicare financing issues which will need attention in the forseeable future. The immediate question is how to finance improved catastrophic insurance benefits, e.g. through across-the-board premiums or means-related taxes from the elderly. The second, longer term issue concerns how to build the much larger financing base which the Medicare program will need to assure its current benefits, as well as catastrophic coverage, well into the next century. The two issues are related in that, in addressing the immediate financing issue, the Committee may establish basic philosophical directions for meeting the larger, longer term needs.

## Should Medicare catastrophic insurance be financed by premiums or taxes from the elderly?

About 93% of Medicare's annual revenues now come from general population taxes (HI payroll tax (65%), general revenues (28%)) and 7% from enrollees' premums. The two most frequently mentioned ways in which the added costs of Medicare catastrophic protection might be financed both involve increasing the enrollees' 7% payment share. The first is through across-the-board premiums for the elderly, which is the way the SMI program has been financed. The second is through resource-related or means-related financing, such as personal income taxes paid by the elderly.

--Premium-based financing The major rationale for premium financing of Medicare catastrophic insurance benefits is that the premiums for such coverage, e.g. $5/month to $15/month, would be easily affordable by many of the elderly. The best evidence for this is that nearly two-thirds of the elderly already purchase such coverage through private Medigap plans. Indeed, because private Medigap coverage has high administrative expenses, many senior citizens would actually save money from paying government premiums rather than premiums for their current Medigap policies. The elderly also have, on average, per capita income after taxes which are slightly better than the under 65 population; thus it is difficult to make a general case that the under 65 should pay for their improved Medicare benefits.

The major problem with using across-the-board premium financing, however, is the poor basic health insurance coverage now available for many of the low income elderly population. This results, in large measure, from uneven (and low) Medicaid eligibility levels. Only about 36% of the elderly living in poverty are now eligible for the Medicaid program. As a result of these gaps, many low income elderly persons, even after Medicare and Medicaid benefits, can face very heavy health care expenses in relation to their income. As of 1984, estimates by Marilyn Moon show that even non-institutionalized elderly persons with per capita incomes below $5,000, after Medicare and Medicaid coverage, still had out-of-pocket health care expenses of 22% of their incomes. These amounts were averages, so many persons had greater financial burdens, as did individuals who were in hospitals or nursing homes and not included in the survey data.

Medicaid's basic eligibility rules have been somewhat modified since these estimates were made, in the Sixth Omnibus Reconcilitation Act (1986) which granted states the option of extending Medicaid eligibility to elderly persons whose incomes do not exceed the poverty level. But these improvements were not mandatory and it is too early to tell how far this option will go in lowering the out-of-pocket burdens of even the elderly population living in poverty.

In sum, there are good arguments for a greater amount of premium financing for Medicare benefits and benefit improvements, but poor Medicaid coverage of the low income elderly population now argues against relying on such across-the-board financing for catastrophic insurance benefits. Public policy should be reducing, rather than increasing, the out-of-pocket burdens of the lowest income elderly. Nevertheless, there is an important long range strategy issue highlighted by this immediate financing dilemma: the Committee will need to consider expanding basic Medicaid eligibility for the elderly if it wishes to take full advantage of the revenue opportunities from premium financing which will be needed to resolve Medicare's long range financing problems.

--Tax-based financing The individual income tax seems the best (indeed, virtually the only) candidate for broad, means-related financing from the elderly. The income tax system is the most equitable, currently available revenue source for such financing. In contrast, the payroll tax (the federal government's other broad population tax) could raise few funds from the elderly because most are retired from the work force. Similarly, the administrative complexity and costs of establishing a separate means-related financing system for 28 million elderly persons, solely to fine-tune financing of a limited catastrophic insurance benefit, e.g. $5 to $15 per month, seem unwarranted.

If individual income taxes on the age 65+ population are used to finance a major part of Medicare's benefit improvements, this could be done either by increasing the adjusted gross income of taxpayers or by higher tax rates. In this regard, there are strong tax equity arguments for increasing the adjusted gross income base to include at least one-half the actuarial value of the HI program and three-quarters of the SMI program costs in the taxable income of the elderly. Such reforms would mean that the income tax would better reflect the full financial resources available to the elderly. These actions would also extend the precedent which this Committee has established by including one-half of social security benefits in adjusted gross income for some elderly persons, and they would also reflect this Committee's tax reform philosophy last year of broadening the income included in the tax base to permit lower rates. In 1987, these amounts would come to roughly $900 per person for HI benefits and about $650 per person for SMI benefits. These amounts could be included in adjusted gross incomes either for all elderly taxpayers or only for those with incomes over the $25,000/$32,000 threshold levels for social security benefits. The following table, from a recent CBO publication, shows the potential revenues:

Revenues

(FY $ Billions)

| | 1988 | 1989 | 1988-1992 |
|---|---|---|---|
| With social security income threshold | $0.7 | $2.5 | $14.0 |
| Without social security income threshold | $1.4 | $5.0 | $25.6 |

Higher income taxes for the elderly population are not, however, without several drawbacks. These drawbacks do not, in my view, outweigh the advantages of using this mechanism, but the Committee should be aware of them.

The most important critique which can be made of financing Medicare catastrophic benefits by the income tax is that the full financial burdens would fall on a minority of the elderly. Social security benefits are still not counted as taxable income for about 90% of the elderly, so a majority of the elderly have no individual income tax liability. Reliance only on income tax financing from the elderly would thus place the full burden of catastrophic benefits for all 28 million elderly on a minority of this group. One critique of such a policy is that higher income elderly persons would be paying taxes for many aged persons who could pay for their own Medicare catastrophic insurance benefits, indeed who are now paying these premiums already for Medigap coverage. A second critique is that the burdens of financing catastrophic health insurance for our lowest income elderly ought to be a broadly shared responsibility in our society, paid for through general tax revenues, not a burden placed solely on elderly persons with high incomes.

The economic impact of this tax liability could be substantial. At the 28% and 33% marginal rates, for example, elderly individuals would face new tax liabilities of about $400–$500 per capita, $800–$1,000 per couple. This would be an unpleasantly large one-year tax increase and would be substantially more than the economic value these taxpayers would receive from a catastrophic insurance plan with benefits of about $15/month ($180 per person annually). As well, such taxes would fall on in-kind (rather than cash) benefits, which are not usually included in the tax code.

The second option for an individual income tax increase would impose an income tax surcharge for elderly persons. This would shift the financing burden even more toward higher income retirees; at higher income levels, an individual's tax liabilities could exceed the value of Medicare benefits. This could be limited by setting a cap on such assessments to assure that no one paid more than benefit costs. Nevertheless, tax rate increases would be less equitable than expanding the income base because increasing the base would spread the burdens more broadly across the elderly population.

In sum, the income tax-financing approach makes a great deal of sense in terms of relating Medicare's financing share from the elderly to their ability-to-pay, as well as improving the general equity of the tax system by including still more financial resources in the tax base. Such a step could now, however, be seen as unfair to the higher income elderly, if used alone, and notably burdensome if imposed all at one time. The income tax approach will automatically become more equitable among the elderly over time, however, since the Congress has not indexed the $25,000/$32,000 limits on counting social security benefits as adjusted gross income. Under current law, more social security benefits will thus gradually come within the individual income tax system. Nevertheless, these current dilemmas of catastrophic benefit financing highlight an important long range strategy issue: the Committee will need to consider expanding the inclusion of social security benefits in adjusted gross income of the elderly to take full advantage of the revenue opportunities from income tax financing which will be needed to resolve Medicare's long range financing problems.

### What are the best revenue sources for financing Medicare's longer term financial needs?

A Medicare financing strategy for catastrophic insurance benefits can also provide the basic elements for meeting Medicare's longer term financing needs: premiums from the elderly combined with improved Medicaid eligibility, plus income taxes from the elderly combined with including more of social security benefits in their adjusted gross income. Through such measures, the Committee could achieve virtually any desired allocation of financing burden among Medicare's beneficiaries by economic status.

Medicare's longer term revenue needs, however, are quite large and will probably require consideration of other tax sources, as well as a broader financing strategy, although there is much uncertainty about the size of these needs. In the 1986 trustees report, the HI trust fund was projected to be bankrupt by the late-1990s and to require added revenues estimated at about $450 billion just to finance current benefits through 2005. Medicare spending will climb very rapidly after 2010 when the baby boom generation starts to retire. As a percent of payroll, the HI deficit could be financed by a .8% tax rate increase through 2010, but projected deficits are 3.0% of payroll over the next seventy-five years, i.e. a $15 billion annual increase in HI revenues, starting immediately, would probably preserve the HI trust fund through 2010, but a doubling of today's $54 billion in HI tax revenues, starting immediately, could be necessary to finance Medicare's benefits for the full seventy five year period. Delaying tax increases now will mean higher rates later. The general revenues needed to finance SMI benefits over this period will be substantially larger, e.g. over $1 trillion by 2010.

Thus, the major issue in developing a longer run strategy for Medicare financing -- and it is, literally, a multi-trillion dollar issue -- is whether or not to "pre-fund" Medicare's future benefits by raising taxes now to build up the Medicare trust funds' reserves. Such a shift from a "pay-as-you-go" to a "pre-funding" strategy was adopted for the OASDI trust funds in the 1983 social security amendments; these funds are now projected to build up reserves of about $10 trillion by 2020 to finance social security benefits for the baby boom's retirement. Those who argue for continuing a pay-as-you-go approach, which tends to shift Medicare tax burdens to future generations, hope for an economic growth dividend from keeping taxes low now so such future costs can be paid out of a larger economic pie. The arguments for pre-funding emphasize that future tax increases would probably need to be so large that taxes would not be raised to cover full costs and Medicare's future benefits would be reduced. This is, however, a more difficult and controversial issue than can be dealt with adequately in this testimony, well worth a hearing in itself.

A second issue in moving from the immediate issue of financing catastrophic insurance benefits to a longer run financing strategy is how to adjust future financing burdens between the over 65 and under 65 populations. At the present time, the balance would appear to favor greater financing from the over 65 population (with the exception of improving Medicaid eligibility) because of their favorable after tax per capita incomes compared to the under 65 population and the extent to which retirees receive far more back than they have contributed. If more of social security taxes and Medicare benefits are included in taxable income, however, the after-tax income difference between over and under 65 populations will also be affected. Similarly, if taxes on the under 65 are used to "pre-fund" their future benefits, the distinctions will involve less a transfer among age groups (as they now are) and more a question of when over their lifetimes today's working population will finance their Medicare benefits.

A third basic set of issues is which taxes should be considered for raising revenues, beyond the premiums and income taxes from the elderly discussed previously. Some of these revenue sources can be used now, of course, as part of an overall financing package for Medicare catastrophic insurance benefits, as well as for longer term financing of basic benefits -- and, I hope, of improved long term care benefits. Among these sources are the following:

--reforming federal estate taxes would be a logical way to help finance Medicare's benefits which protect the elderly's incomes and estates. There are very substantial revenue possibilities from this source. In 1984, for example, the total net worth of the 65+ population was reported to be about $2 trillion. (Bureau of the Census Household Wealth and Assest Ownership: 1984 Series P-70 No.7). As of 1984, the median net worth of elderly households exceeded $60,000, compared to $33,000 for all households. (The mean net worth of elderly households was nearly $105,000 compared to $79,000 for all households). Most of these funds would now avoid taxation because of the exclusion of estate and gift taxes below $600,000 from current taxes. Assuming a 5% turnover in the $ 2 trillion annually to a younger generation, the taxable base now would be about $100 billion per year. Even modest taxes on this amount would raise substantial revenues, and these amounts can be expected to grow rapidly as the under-65 generations have their own savings enhanced by inheritance from their parents. Even by 1984, the mean average net worth of households headed by 55-64 year olds ($130,000), with most of their earning years since the Depression, was already nearly 25% greater than net worth of the 65+ population. The estate tax has the added virtues of not falling on earnings or normal income streams (like the payroll and income taxes), of reducing the build-up of economic inequality based on an individual's inheritance rather than his or her contribution to society, and of allowing a generation to pay its medical bills through savings accumulated during their lifetime without a direct tax on the earnings of the next generation. With use of the estate tax, in addition to current revenue sources, Medicare's benefits would be partly "prepaid" by a generation (payroll taxes), partly "pay as you go" financed (premiums/income taxes from the elderly), and partly "paid after you went" (estate taxes).

--increasing the tobacco and alcohol excise taxes. This step was recommended by the 1982 Social Security Advisory Council (Medicare) to reflect the added Medicare expenses which result from use of these products. These rates also have not kept pace with inflation over the past several decades and have fallen as a proportion of product costs. On the other hand, it is difficult to attribute exactly the higher Medicare costs to these sources. A doubling of these rates would raise about $8.7 billion in revenues.

--expanding HI payroll tax coverage to include state and local employees hired prior to March 1986. This was recently suggested by the Reagan administration. It would be justified on the basis that most of these employees will eventually receive Medicare, as well as for consistency with recent coverage of new state and local employees. This reform also would increase the base of taxable income, without raising rates, a general direction of recent tax reforms. Estimated revenues are $1.6 billion in 1987.

--selective broadening of the adjusted gross income definitions for the personal income of the under 65 population, or, possibly, a modest rate increase. The taxation of some amount of employer contributions for health insurance and life insurance, for example, would complement the inclusion of part of Medicare and social security benefits in the adjusted gross income of elderly taxpayers. An earmarking of such revenues for Medicare (or Medicare, OASDI, Medicaid and SSI) would help to "prepay" some of

Medicare's future benefits and assure it's future solvency, and would probably be more acceptable than simply putting such amounts into general revenues. A broadening of the taxable income base, without increasing personal income tax rates, would also be consistent with recent tax reforms. CBO estimates suggest that taxation of employer health insurance contributions beyond $80/month for individuals ($200/month for families), a Reagan administration proposal, would bring in about $1 billion in revenues initially, while full taxation of such contributions, offset with some tax credits, would produce about $7 billion in first-year revenues.

--a slight (.05%) rise in the HI payroll tax, e.g. from 1.45% to 1.50%, and/or an increase in the wage base. This would provide a general population contribution from a highly productive revenue source which is accepted by employers and employees. Nevertheless, payroll tax financing for the Medicare program can be criticized as inequitable because, unlike the use of payroll taxes to finance retirement benefits, there is no relationship between an individual's wage history and his or her Medicare benefits. The wage base increase would target higher income persons, while rate increases would increase the burdens from the first dollar of earnings. Estimated revenues from the rate increase are about $2 billion in 1987.

Of these potential revenue sources, it seems to me that the estate tax has the most to recommend it. Estate tax reform would be a well-justified, productive and virtually untapped source for the substantial sums which will be required for the Medicare program to continue and expand its benefits without imposing far heavier burdens on the under 65 population. Raising tobacco and alcohol taxes also seems desirable in terms of both Medicare financing and public health policy. Nevertheless, most or all of these sources, as well as premiums and income taxes from the elderly, will probably need to be tapped to finance Medicare's current benefits and future expansions to meet the health and long term care needs of our growing elderly population.

## Questions from Senator Mitchell

1. Question:
   Mr. Etheredge since coverage for nursing home benefits without the impoverishment needed for Medicaid would benefit the estates of older persons, do you think it is reasonable to use estate taxes as on means of financing a long term care benefit?

2. Question:
   If we would consider pre-funding of a long term care benefit, do you think it should be via require social security tax, income tax, mandated employee/employer private insurance or voluntary employee funded insurance.

## Responses to Questions from Senator Mitchell

Lynn Etheredge

1. The estate tax would be one of the best financing sources for a new long term care benefit. It is quite reasonable to use estate taxes since these long term care benefits would protect the elderly's estates. This is now a virtually untapped (and declining) federal revenue source, accounting for less than 1% of federal revenues in 1986. But with assets of the elderly of nearly $2 trillion in 1984, there is more than enough potential revenue base to finance a catastrophic long term care benefit. And the elderly would be much better off with such protection than with the extremely poor "spend down" floor now provided by Medicaid, which requires exhausting nearly all financial assets to the point of impoverishment before any benefits are provided.

2. To the extent that long term care benefits are pre-funded by government from sources other than the estate tax, a broad-based, progressive tax makes the most sense. This would be either the income tax or the consumption tax. The payroll tax, since it applies to the first dollar of earnings of low wage workers and includes only wage income, is not as fair a way to finance new benefits, although removing the upper limit on covered wages would help to raise more revenues in a progressive manner. A mandate for new employer-employee insurance should go first, in my view, to requiring basic health insurance for current workers before adding long term care benefits. But I would favor requiring

employers offering ERISA and other pension plans to make available a "cafeteria" of options for retirees, i.e. different lump sum drawdown & annuity options, basic health insurance (until a retiree has Medicare eligibility), Medicare supplements, long term care insurance, etc. This would automatically produce a private long term care insurance market, for at least half of the work force, which would "fill in" below a Medicare catastrophic long term care benefit. By using this "cafeteria" approach, the Committee can assure that workers with pension coverage will automatically have long term care insurance available, plus the advantage of pre-financing through tax-favored savings. In contrast, trying to establish new, separate retirement savings plans which would fund only long term care insurance, which is the other option for employer-based prefunding, seems to me unnecessarily complicated and fragmented approach to retirement planning. Workers without basic pension plans would be better off if such mandates were first used to assure their needs of retirement incomes. New benefit mandates for long term care insurance would also tend to meet a lot of resistance as increasing employer's liabilities for retiree health-related benefits. But I can see no reasonable objection to a requirement that employees have a "cafeteria" of options for how to use the tax-favored savings which they have put aside for their retirement needs.

## STATEMENT OF RONALD F. POLLACK, EXECUTIVE DIRECTOR, VILLERS ADVOCACY ASSOCIATES, WASHINGTON, DC, ACCOMPANIED BY EDWARD HOWARD, PUBLIC POLICY COORDINATOR

Mr. **Pollack**. Thank you, Mr. Chairman, and thank you for the chance to testify at this hearing. I am accompanied today by Edward Howard, the Public Policy Coordinator for the Villers Advocacy Associates.

The Villers Advocacy Associates is a nonprofit group concerned with low- and moderate-income older people, so my testimony today will focus on how the proposal on this important issue touches their lives, the lower-income seniors, or leaves them untouched.

Medicare has been a boon to seniors; yet, despite the $80 billion spent by Medicare this year, older Americans will spend this year as large a share of their incomes on health care as they did before Medicare was enacted. The reasons are simple: There are co-payments, deductibles, and premiums; there are uncovered services; and there are high payments out of pocket for some covered services, especially to doctors who don't accept assignment.

The White House plan to deal with these problems is unfortunately as full of holes as Medicare itself. The only one it claims to plug is the risk of spending more than $2000 a year on certain kinds of health care expenses.

The White House claims its plan will help approximately 1.2 million people, or about 4 percent of Medicare beneficiaries. But a large proportion of those people are on Medicaid, so it is too late to protect them from catastrophic expense; and 40 percent, according to the current population survey of the elderly, have liquid assets of less than $2000, so the White House plan would give them no benefits until they have spent their entire life savings.

Who would benefit? Pretty clearly, those with lots of assets to protect from financial catastrophe. And how would the White House plan pay for these benefits that protect people with significant assets but do little or nothing for low-income seniors? In essence, by reducing everyone's Social Security check by $6.40 a month, rising to $12.20 in 1992. Yet, it is higher-income seniors who would get the benefits, because they are the ones with more assets at risk from a long hospital stay. Lower-income seniors would probably pay the premium but would get very little benefits in return.

In my written testimony you will see, on page 9, a brief table showing some rough cost-benefit ratios for some income groupings of seniors. As we indicated on pages 8 and 9, for seniors with incomes greater than $20,000, the White House plan would be a very good deal. They would get back about $1.66 in benefits for every dollar they paid in premiums—it would be a very good deal. But for seniors under $5,000 in annual income, the return is just 2 cents on the dollar—a pretty bad investment, I believe you will agree. And the reason it is such a poor investment is that, for many people, their total assets will have been depleted before the $2000 cap has been reached. Some are already receiving Medicaid. And so for many of these people, this proposal is not going to affect them.

Catastrophic insurance is like assets-protection insurance. Yet, the Administration's financing scheme violates fundamental precepts of such insurance. It is as if the owners of a $2 million mansion were to be charged the same fire insurance premium to protect their home as were the owners of a $20,000 hovel—it is just unfair.

In sum, for lower-income seniors, the White House catastrophic plan is worse than no plan at all. It provides little or no benefits; those benefits are skewed away from low and moderate income seniors; its financing plan is regressive; and its passage would harm efforts to deal with the real problem of catastrophic costs.

So, how should the White House plan be changed to affect that portion of the senior population? I would like to suggest three options. Neither of them I think you will find are fiscally irresponsible.

One: Coverage for the poor and near-poor through Medicaid. The catastrophe for this group of seniors comes not from hospital stays longer than 60 days, but from paying that very first day the $520 deductible. The co-pays and premiums are burdensome, too. States should be required to pick up the Medicare cost-sharing for elderly and disabled up to the official poverty line, and should be given the option of picking up the cost-sharing up to 150 percent of the poverty line. It is noteworthy to point out that such a change in the Medicaid law would not—and I stress would not—increase Medicaid costs for the Federal Government or the states. This is because the basic catastrophic package will significantly reduce Medicaid costs for the Federal Government and the states by causing Medicare to pick up various costs in lieu of Medicaid. Indeed, the Medicaid proposal I am suggesting, having Medicaid programs pick up Medicare's Part A deductible, as well as the Part B premium deductible and copayments for impoverished seniors, is less costly than the Medicaid savings from the catastrophic package. This is both true on the federal side as well as on the state side. Thus, this proposal not only would make the package more equitable but is fiscally sound as well.

The CHAIRMAN. Thank you very much, Mr. Pollack.

[Mr. Pollack's written prepared testimony follows:]

# CATASTROPHIC HEALTH CARE

Statement by

RONALD F. POLLACK
Executive Director
VILLERS ADVOCACY ASSOCIATES

before the

SENATE COMMITTEE ON FINANCE

Washington, D.C.

Thursday, March 26, 1987

Mr. Chairman and members of the Committee, thank you for this chance to testify. Your quick attention to the problem of catastrophic health care expenses, particularly among the elderly, deserves special thanks from everyone concerned about it.

Although my comments today will focus on the elderly and disabled, and how their specific health care burdens can be eased, let me emphasize that older people and those working on their behalf are deeply concerned about the lack of health care access among the 37 million Americans with no health coverage at all -- the unemployed, workers with no coverage, the poor who don't qualify for Medicaid, and their families.

Since our organization's major concern is for low- and moderate-income older people, the bulk of my testimony will be concerned with the programs aimed at providing health care coverage for them through Medicare and Medicaid.

When President Lyndon Johnson signed Medicare into law a generation ago, he hailed the dawn of a new era: "No longer," he said, "will illness crush and destroy the savings that [older Americans] have so carefully put away over a lifetime, so that they might enjoy dignity in their later years."

Medicare has been a blessing to millions of older persons. But the lofty dream expressed by President Johnson has only partly come true, and, for low-income seniors, health care costs continue to be a nightmare.

## GAPS IN MEDICARE COVERAGE

Medicare was enacted because, America concluded, our older citizens were spending too much on health care. Yet more than 21 years later, older Americans spend as much out of pocket on health care -- about 15%, on average -- as they did before Medicare was enacted. I know, Mr. Chairman, that you have heard that fact before, but I believe it bears repeating. Those out-of-pocket expenditures among the elderly are three times those for younger Americans: $1,055 per older person in 1984, versus just $310 out of pocket for younger persons, and these figures do not include the costs of long term care.

### Hospital Coverage

Although, in general, Medicare coverage for hospital stays is good, holes remain in the protection. The $520 deductible -- up 155% in just the last six years -- remains a significant burden, especially for the 20% of beneficiaries who have no supplemental, or "Medigap," insurance. And those few who experience hospital stays greater than 60 days -- fewer than 200,000 out of 28 million elderly Medicare beneficiaries -- risk being required to pay thousands of dollars out of pocket.

## Physician Coverage

Part B of Medicare, which covers physicians' services, is woefully inadequate. Before Medicare will pay a dollar toward these bills, an elderly beneficiary must pay a monthly premium that totals $215 a year, and meet an annual deductible of $75. Only then will Medicare pay 80% -- of its approved charge, not of the actual bill. Doctors are free to charge more, and seven out of ten doctors do just that for some of their patients. So the true copayment facing many patients is not 20% but 30, 40, even 50%.

## Uncovered Services

Drugs. Medicare will not pay for prescription drugs, though older Americans depend on them to a far greater extent than others in the population. The millions of elders suffering from such chronic conditions as high blood pressure, diabetes, various heart conditions and some types of cancer, depend on medication to help control those problems. Those costs come almost exclusively out of pocket. Some 6.7 million older Americans -- 24% of all seniors -- are taking three or more prescription drugs. And from January 1980 through 1986, prescription drug costs rose about 80% -- 2 1/2 times faster than consumer prices in general.

Prevention. With very limited exceptions, Medicare will pay for nothing that aims to prevent illness or disease, or that maintain health, like physical examinations, or health screening, or preventive vaccines.

Other Services. Seniors in need of foot or eye care, or dental attention, or in need of hearing aids, eyeglasses or dentures, quickly discover that Medicare virtually ignores these needs.

Transitional Care. As Medicare's prospective payment system has pushed more elders out of the hospital "quicker and sicker" and in need of more intensive services, beneficiaries increasingly find themselves in a "no care zone." This problem has been terribly exacerbated by the current Administration's (we believe unlawful) efforts to reduce the amount of home care available after hospital stays.

Long term care. Although persons of all ages develop chronic conditions that limit their ability to function in the community, the chances of developing such a condition increase dramatically with age. An official survey in 1982 found that 18% of those over 65 had limitations in such basic activities as bathing, dressing, eating, cooking or cleaning. That's in addition to the million and a half older people for whom these physical or mental disabilities required care in a nursing home. Medicare covers only the tiniest fraction of the cost of providing this care, whether in institutions or in the community.

There is one major governmental help in paying for long term care: the Medicaid program. Unfortunately, in most states, Medicaid pays for only institutional care, that is, nursing homes. Further, eligibility and program rules almost force a person -- and his or her spouse -- to become impoverished in order to get Medicaid assistance.

ADMINISTRATION RESPONSE FALLS SHORT

On February 12, the President announced White House support for a plan to partially restructure Medicare. In his statement, the President captured the essence of the problems needing attention:

> A catastrophic illness can be a short-term condition requiring intensive acute care services or a lingering illness requiring many years of care. It can affect anyone....The single common denominator is financial. It can require personal sacrifices that haunt families for the rest of their lives.

HHS Secretary Bowen deserves credit for pushing this issue to the fore in the Administration, and the President deserves credit for taking the Secretary's advice, calling attention to this crushing problem, and helping to define it.

But as to the proposal put forth by the Administration to remedy the problem, I regret that I must be much less positive. The White House plan leaves so many holes in catastrophic health protection -- even for seniors -- that many of us have begun describing it, not as an "umbrella," but as an uNbrella, exposing millions of older Americans to torrents of devastating health care bills.

-- There is no relief for the millions of older Americans in need of vision care, dental care, foot care, or hearing aids and other devices needed to improve these areas of functioning.

-- There is no help for older Americans from the $8 billion they spend each year on prescription drugs.

-- There is no movement to reduce later, greater health expense from acute illness -- and the suffering it represents -- by providing preventive or health maintenance services.

-- There is only the slightest gesture toward restraining the billions of dollars spent on doctor bills. For every dollar older Americans spend out-of-pocket on hospital cost, they spend $4 on physicians.

-- There is no recognition in the plan of the President's definition of the problem -- that of financial devastation. The White House plan uses the same flat, narrowly defined and very high amount -- $2,000 in spending for specific, Medicare-approved expenses to trigger catastrophic protection for all, despite the considerable variation in burden it represents for well-off seniors, on the one hand, and moderate- and low-income seniors on the other.

-- Most fatally, there is no mention of the most catastrophic health care expense for the elderly, that of long-term care. Among those who actually spend $2,000 out-of-pocket in a year, more than 80% of the total goes to pay for nursing homes. For every dollar they spend on hospitals, America's elderly spend $8 out of pocket on long term care.

Even among the people claimed to be helped by the White House plan, there is considerable overstatement. The assertion is that 1.2 million persons -- about four percent of 28 million elderly Medicare beneficiaries -- will benefit from the plan. Even that overstates the plan's impact.

For one thing, of the 1.2 million people claimed to "benefit" from the White House plan, some 950,000 now have catastrophic coverage through either Medicaid or private Medigap. That leaves just 350,000, according to the Administration's own calculations.

Second, the Urban Institute has calculated, based on the March 1984 Current Population Survey data, that 43% of all elderly had liquid assets of less than $2,000. Even adjusting to account for those with Medicaid or Medigap, it is clear that some of the 350,000 claimed beneficiaries of the White House plan would have their life savings completely wiped out before ever reaching the trigger for protection.

Another way to look at this issue is by returning to the definition of "catastrophe" for those purposes. Surely, someone spending 20% of family income on health care has suffered a catastrophe. Under current law, according to Dr. Judith Feder of the Georgetown Health Policy Center, about 18.2% of older people with incomes below $10,000 spend more than one-fifth of their total income for health care. How does the White House plan help them? Virtually not at all. Under it, 18.2% of these economically vulnerable people -- unchanged from current law -- would still spend one dollar in five for health care.

Finally, the financing suggested for the White House plan makes the package, taken as a whole, look like "Robin Hood in reverse."

Clearly, those who will benefit from the White House plan will be, disproportionately, those with substantial assets to protect. At the very least, they will find their Medigap premiums reduced to reflect greater governmental protection of those assets.

Yet the financing mechanism for the White House plan is a flat, $6.40 a month premium (rising to $12.20 by 1992), identical for rich and moderate income and poor alike.

It is as if the owners of a $20,000 run down hovel were to be charged the same fire insurance premium to protect their home as were the owners of a $2 million mansion.

The result, according to Dr. Feder, is that an elder with income under $5,000 would get back an average of just 2 cents for each premium dollar paid, while those with incomes over $20,000 would receive $1.66 in benefits for each premium dollar (See Table A).

TABLE A

Distribution of Benefits and Premium Costs

from Bowen Plan

| Persons with Income | Benefits | Premiums |
|---|---|---|
| Less than $5,000 | 0.2% | 10.5% |
| More than $20,000 | 17.6% | 10.6% |

Surely Congress will not allow this regressive redistribution.

## RECOMMENDATIONS FOR FURTHER IMPROVEMENTS

From the standpoint of moderate- and low-income older people, we would urge you to take further steps to plug some of the numerous gaps you have heard identified in your hearings. Here are a few suggestions:

1. Protect the economically vulnerable. At the very least, better protection is needed for poor and near-poor elders. States should be mandated to allow elders below the poverty line to have Medicare out-of-pocket payments paid for through Medicaid. A buy-in mechanism, with sliding scale premiums, could be established for those below twice the poverty line.

2. Other Medicaid expansions. Perhaps no greater catastrophe occurs than that suffered by one spouse when the other must enter a nursing home. Senator Mitchell, distinguished Chairman of this panel's Health Subcommittee, and Senator Mikulski, who has worked

**on this issue for years, have shown leadership on this issue. Their proposals offer a good framework for responsibly ending this "spousal impoverishment" absurdity.**

3. Strengthen transitional care. **The skilled nursing benefit** has been illusory, deceptive and inordinately expensive for many who do receive it. Home health, which should be of greater and greater importance as hospital stays shorten under prospective payment, disappears over the horizon as the Administration squeezes the intermediaries to control costs by any means. Congress should reassert its intent that these and other transitional services should be routinely available when the patient's doctor says they are needed. Further, they should not be encumbered by cost-sharing so burdensome the benefit is unattainable.

One indisputable fact is that Medicare's prospective payment system has forced numerous of older and disabled people out of hospitals sooner-- thus depriving them of some or all of the coverage for services they would have received in those extra hospital days. Most likely, they still need those services, and either are not receiving them at all or are paying for them out-of-pocket.

4. Add needed services. The case for providing prescription drugs under Medicare is stong. Eight states already recognize this need, and have not experienced unmanageable expense. Modest preventive services could identify potential major health

problems at earlier, more treatable, stages. Vision, eye, dental care, and medical appliances should be added.

5. Lower, broaden the cap. The $2,000 cap envisioned in the White House plan will expose millions of elderly to catastrophic expenses. Dr. Feder estimates that even a $1,500 cap, even one that included prescription drug costs, would reduce the proportion of the economically vulnerable spending 20% of their income on health care only from 18.2% to 17.8%. A much lower cap, and one that includes more expenses not paid for by Medicare, should be the goal. Even more desirable would be a comprehensive cap tied to income, since, as the President noted, what is being discussed is financial catastrophe, a relative concept.

## FINANCING IMPROVEMENTS

If the Committee acted favorably on all of these recommendations, the price tag would be substantial. But we believe the climate is right for pursuing this agenda, and the resources to pay for them are within grasp. A number of financing possibilities exist, among which are the following:

First, use a tax-system-related mechanism for financing, such as the one suggested by H.R. 1280 the Stark-Gradison bill. Another approach might be simply a tax surcharge on the elderly, which would be even more progressive, and less fraught with the philosophical problems of counting in-kind benefits as income.

Second, make state and local public employees begin paying into Medicare, which virtually all of them will benefit from when they retire.

Third, look closely at tobacco tax increases, and denial of deductions for tobacco advertising, in recognition of the substantial Medicare expenditures caused by smoking.

Fourth, explore ways to adjust payments to hospitals, in view of recent revelations about hospital profit margins under prospective payment.

## CONCLUSION

Mr. Chairman, you and your Committee colleagues deserve much gratitude for spotlighting the importance of patching the catastrophic expense holes in our current health system, for elders and all Americans.

We urge you to seize this opportunity to fashion a bold, but fiscally balanced initiative, and we look forward to working with you in shaping and supporting a responsible and compassionate proposal.

To do less would be the worst catastrophe of all.

The **Chairman**. I see it is 12:35, and we are in competition with events on the Senate floor.

You have addressed some of the toughest issues—how we pay for catastrophic coverage, and who pays for it—and I think the information you have provided us is going to be very helpful. Some of it is going to be difficult to get a consensus on. But I am confident we will do it.

Your testimony shows us some of the benefits and some of the pitfalls we face. It certainly shows the merits of trying to at least cut the cost to the poor and the near-poor.

Thank you very much for your testimony. We appreciate it.

The hearing is closed.

[Whereupon, at 12:35 p.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

Community Council of Greater New York

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26th C

April 3, 1987

## REMARKS
## SUBMITTED BY COMMUNITY COUNCIL OF GREATER NEW YORK TO THE UNITED STATES SENATE COMMITTEE ON FINANCE FOR THE RECORD FOR THE HEARING ON THURSDAY, MARCH 26, 1987
## ON
## CATASTROPHIC HEALTH INSURANCE

The Community Council of Greater New York is the human services information, advocacy and monitoring agency for New York City. It has served in this capacity for more than 60 years. During this time, it has been particularly concerned with the needs of older people, as evidenced primarily through its Citizens' Committee on Aging which has worked over the years on a variety of health-related issues, including the original "Medicaid" planning in New York State, home care and other long-term care issues, and more recently, a Task Force which assessed the "Medicare" program and made a series of recommendations relative to the future of that program and its Trust Funds.

The Committee and the Community Council are committed to working for the improvement of long-term care programs. We are seriously concerned that the current dialogue around "Catastrophic Health Insurance" will result in the over-simplification of the issue, without sufficient relevance to the need to postulate the "Catastrophic" issue as part of the more complex issue. Our positions on this issue are based on the following principles which we would like to see used as tests for the adequacy of any "Catastrophic" program.

A
Greater New York Fund/United Way
Agency

1. A PLAN MUST BENEFIT ALL AMERICANS -- poor, near-poor, uninsured, and underinsured.

There is a bipartisan agreement on the seriousness of the problem of health care coverage for the poor, near-poor, underinsured and uninsured.

There is a general misconception by some that private group health insurance from one's job is taking care of the financial problem of meeting health care costs for workers and their families and that any residual problem is being taken care by the Medicaid Program for low-income people. This, however, is NOT true. "Medicaid's" income eligibility level fell below 55 percent of the Federal poverty threshold in 23 states in 1984, drastically reducing the numbers of those eligible. Group health insurance for workers is widespread, but many in low-paying or part-time jobs or who work for small employers are not covered. Between 1978 and 1984 the numbers of persons without health insurance has increased from 28 million to more than 37 million.[1]

2. A PLAN MUST PROVIDE FOR A COMPREHENSIVE RANGE OF INSTITUTION AND COMMUNITY-BASED LONG TERM CARE SERVICES

A major issue, of late, is how to provide the needed care as well as protection against the devastating catastrophic costs faced when chronic illnesses and disabling conditions strike.

Many individuals are under the false impression that they have coverage for long term services. However, most insurances deal largely with the cost of skilled medical treatment for acute illnesses and do not cover the needs of the typical, chronically-ill long-term care patient, who for the most part, does not require the services of a physician or a skilled nurse but rather help with custodial-type care, i.e., dressing,feeding, toileting.

"Medicaid," the program most closely identified with long term care nursing home expenditures, does not provide much assistance for home care. Presently, "covered" long-term care services are received almost entirely in institutions. Yet, most long-term care is not provided in nursing homes. Seventy percent of the people with long-term care needs live in private residences receiving assistance from family, friends and/or professional service agencies.[2]

The Committee and the Community Council feel strongly that a plan must provide coverage for a range of services along a continuum--from community-based services to institutionally-based services allowing individuals the flexibility and freedom to utilize the type of care setting that best suits their needs and enables one to retain a sense of dignity and independence.

3. A PLAN THAT IS AFFORDABLE FOR ALL AMERICANS

We are the only industrialized nation in the world that has no system for guaranteeing affordable health care for all. The "Medicare" program was originally enacted with the notion that access to good health care was the right of all Older Americans and there should be no discrimination to access based on a person's ability to pay for care. Unfortunately, even the Federal program has not been able to accomplish this mission. That is, "Medicare" covers only about 40% of older people's medical care costs.

The financial barriers to escalating health care costs for individuals are widening. Also, the long-range societal costs of an inadequate, badly fragmented, and complex combination of private and public insurance programs, make it obvious that we can no longer afford not to act.

The Committee and the Community Council are not in a position, at this time, to propose specifics on an "affordable" health plan since we are still reviewing alternative delivery models and financing plans. However, we cannot lend our support to any proposed plan that disproportionately places the greatest financial burden on the sickest and poorest and places little emphasis on the plan's long-range cost effectiveness along with quality of care issues.

In summation, we are pleased that the debates over this issue have at last begun and hope to see soon an effective catastrophic plan focusing attention on the full catastrophic health problem. We feel a plan must guarantee health coverage for everyone, provide for both community-based and institutional long-term care services, and be affordable for individuals and the government.

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[1] Ball, Robert M., "Gaps in Health Care Insurance Coverage of the Elderly." Presented at a hearing of the Senate Labor and Human Resources Committee on Health Costs for the Nation, January 12, 1987.

[2] Ibid.

[redacted]

HFMA

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# STATEMENT OF THE
# HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION
# TO THE
# U.S. SENATE FINANCE COMMITTEE
# APRIL 7, 1987
# ON
# HEALTHCARE COVERAGE FOR CATASTROPHIC ILLNESS

The Healthcare Financial Management Association (HFMA) enthusiastically endorses more adequate federal financial participation in the catastrophic illness services than are now being provided. However, we caution against the creation of expectations among the public or others about funds that will be available for new and expanded healthcare services when funding of current services has such significant shortfalls. There must be adequate funds and equitable arrangements for paying for catastrophic health services.

Catastrophic illness is a significant national issue. HFMA applauds the attention being brought to this issue. The goals of covering especially difficult and costly cases, meeting long-term care needs, and protecting the uninsured and underinsured are worthy. But there are some significant downside risks for healthcare providers. Added promises to beneficiaries must be accompanied by adequate payments to the providers of the services. The government's past practices of making promises and then changing the payment rules later leaves us very skeptical.

## ABOUT HFMA

HFMA is a professional membership association composed of over 25,000 individuals in 75 chapters who share an interest in financial management of hospitals and other healthcare institutions. HFMA has long been involved in the development of appropriate methodologies for paying for healthcare services. In May 1982, HFMA issued its recommendation for prospective price setting methodologies. In October 1985, we issued a statement dealing with the "Definition of and Payment for Uncompensated Services" (copy attached). In May 1986 each of our 75 chapters was asked to study the issues raised by the Secretary's Private/Public Sector Advisory Committee on Catastrophic Illness. This statement reports to you the concerns expressed by HFMA members based on their years of experience with various arrangements for paying for healthcare services.

## CURRENT PROVISIONS FOR ESPECIALLY DIFFICULT AND COSTLY CASES

Especially difficult and costly cases are currently being served. These services may be covered by Medicare DRG payments, or the patient may be responsible for uncovered services, deductibles, and coinsurance.

### Medicare Payments

When Medicare beneficiaries require acute care services of catastrophic proportions, these services are provided. Reportedly, only 2 percent of Medicare beneficiaries exhaust their benefits, which is rather clear evidence that catastrophic services that are covered by Medicare are being provided.

If catastrophic service is covered by Medicare, payment probably involves the Medicare "outlier" provisions -- extra payments for extraordinary cases that are especially costly or lengthy. These additional payments bear little relationship to the cost of services provided. This is a seriously deficient feature of the current PPS system.

Congress has already provided the outlier mechanism for meeting some catastrophic acute care needs of Medicare beneficiaries. HCFA is distorting this provision by paying far less than Congress provided. Even though HFMA, the Prospective Payment Assessment Commission (ProPAC), and others have requested data about actual outlier payments, the Health Care Financing Administration (HCFA) has not released actual outlier payment data on a timely basis. The experience with this arrangement makes healthcare providers skeptical about equitable administration of any new, federally administered catastrophic program.

The outlier payment arrangement should be changed, regardless of new catastrophic coverage, to:

- Make payments fully in accord with congressional direction;
- Require regular reporting of actual payments for outlier cases;
- Raise the ratio of cost paid for outlier cases; and
- Remove the linkage between day and cost outliers.

## Uncovered Services

Many other services of a catastrophic nature are also being provided to Medicare beneficiaries in the form of post-acute care, extended care, and noninpatient care for which Medicare coverage is unavailable or, in many cases, inadequate.

Much of this service is uncompensated to the provider and no governmental program shares in these costs. In addition, services are provided to many people who are uninsured or underinsured due to unemployment, failure of employers to make adequate insurance available, and personal decisions to forgo or limit insurance coverage.

Medicare, as the largest payer of healthcare services, and other federal or state programs makes no contribution to the uncompensated portion of these services. The government is shifting its financial responsibility for these services to others. It is time for Medicare to meet its proportionate share of these costs.

## Deductibles and Coinsurance

Deductible and coinsurance provisions make some of the payment for currently provided services the patient's responsibility. Medicare beneficiaries may insure this obligation with Medigap insurance, but this coverage would be replaced by the extended Medicare benefits envisioned under some catastrophic proposals being discussed. Patients who currently receive catastrophic services that Medicare or Medigap does not cover may pay out of their own pocket, but it is likely that many such cases are uncompensated and are added to providers' charity load.

The current deductible and coinsurance payments are not related to cost of service in any way. Thus, if payment for catastrophic service simply pays what patients might pay under the current deductible and coinsurance provisions, the providers will not get payments that are even remotely related to cost.

If beneficiaries are required to pay a significant amount (Secretary Bowen's plan specifies $2,000 a year) much of this will result in bad debts. While Medicare currently pays for bad debts, HHS Inspector General says this payment is inconsistent with prospective rates -- a fallacious argument as long as PPS rates are a roll forward of rates from an era when this payment was part of the formula. Deductible and coinsurance provisions must not add to the burden of uncompensated services.

## UNCOMPENSATED SERVICES

A special HFMA task force has studied uncompensated services. It reached the indisputable conclusion that "if institutional healthcare providers are to remain financially viable, there is no alternative but for payers to pay for uncompensated services."* Providers cannot provide services if payment is inadequate. Thus, the responsibility for financing catastrophic services must not be shifted to healthcare providers.

Provision of uncompensated services is a real and legitimate business expense and all customers should share in this cost. Food given to the needy and credit losses incurred by a grocery store are an integral part of the prices paid by all customers of that grocery store. The same is true in any business. Similarly, Medicare must share in the financing of uncompensated services provided to non-Medicare patients.

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*HFMA's statement concerning "Definition of and Payment for Uncompensated Services and Special Problems of a Disproportionate Share" is attached.

Recent legislation provides supplemental Medicare payments for the higher cost of serving Medicare patients by providers with a disproportionate share of uncompensated services. This provision does not address the uncompensated services problem, however. Congressional action to limit payments for outpatient services, even when the provision of such services is most cost effective, further exacerbates this problem.

The current procedure of indirect taxation through payment shortfall in Medicare and other government sponsored programs is not an appropriate model for meeting catastrophic illness requirements. It is essential to recognize that services that are provided must be paid for by someone and Medicare must pay its share.

## INCREASED DEMAND

A government promise to cover the most difficult circumstances that require acute care services, to cover long-term care services, and to cover services to the uninsured or underinsured will doubtless foster provision of even more of these services than in the past. This is a desirable result for beneficiaries, of course, but a risk for both the government and providers. We only need recall the results of coverage of renal dialysis services to recognize that increases in demand and huge increases in cost will result. The ESRD program is clearly beneficial. Lives have been improved, extended, and saved. But the costs have been much greater than expected. If more catastrophic services are to be provided, the payment arrangements for these cases is a critical consideration. The government must recognize and be willing to accept the financial consequences of its public policy decisions. One of our chapter groups raised the pertinent caution that "the program will promise much and pay for little."

Diminished insurance coverage of patients' financial responsibilities, any change in arrangements for Medicare payment of bad debts, and the inadequate payments that result from the current "outlier" methodology all raise questions about the adequacy of payment for catastrophic services. These are concerns even at current levels of service and even more serious concerns if more catastrophic services are called for.

## RULES CONCERNS

Providers also have no difficulty recalling the many ways that the government changes the payment rules after the game has begun. This happened repeatedly in the Medicare cost-based payment era and has continued with new creativity under PPS. The original goal of PPS was to limit the rate of increase in federal healthcare expenditures. Providers were offered the opportunity to profit through fulfilling that goal. The federal government has not only controlled expenditures, but has saved tremendous amounts in comparison to what would have been spent under the former system. But rigid budget targets resulted in changed rules and frozen rates; denying providers the promised rewards that were part of the original plan.

Revenue from new catastrophic insurance premiums could go a long way toward solving the federal deficit if the government devises ways to promise the services but avoid paying for them. The government will not, of course, simply receive and keep the revenue while telling the healthcare industry to provide increased services with no increase in payments. There are alternatives for changing the rules to achieve the same result, however. Current consideration of "rebasing" is an example. This is just a euphemism for lowering the rates hospitals are entitled to. Another option is for the government to freeze rates for current services, pay something for additional services, and say that total payments have increased.

The "case-mix shuffle" can also be used to avoid paying for expanded catastrophic coverage. (The government has reduced PPS rates to offset much of the effect of increases in case mix, the measure of the relative complexity of cases served. While everyone agrees that rates should not increase because of changes in case coding practices, the industry contends that cases served are really more complex and has challenged the government to do a study to measure the change in coding practices, but the government has refused.) As more catastrophic cases are served, the government can contend that the increased complexity apparent in higher case-mix amounts is just the result of a change in coding practices and deny higher payment for these more complex cases. Adding to this concern, some case weights have been decreased thereby lowering payment for comparable cases. The manipulation to payment by changing case mix is inappropriate.

Failure to recognize increased severity adds to our concern about the inequity of case-mix arrangements. Patients are being kept alive that would have died and costly new technologies are more broadly available. Thus the high cost of serving catastrophic cases is not adequately measured by the current case weight system. Changes in severity of illness must be recognized.

Payment rules must honor the original commitments, must not offset real case-mix change by rebasing and case-mix adjustments, and must recognize severity changes.

## CONCLUSION

Attention to catastrophic illness issues is timely. We enthusiastically endorse more adequate federal financial participation in the catastrophic illness services that are now being provided. We support better access to catastrophic service for as many people as our nation's economy allows. We also support a financial relationship that is equitable and protects the interests of all people.

RRK/mlh

4/7/87

Statement

By

Karl D. Bays
Chairman of the Board
Baxter Travenol Laboratories

Representing The

Health Industry Manufacturers Association

To The

Committee on Finance

United States Senate

April 7, 1987

Mr. Chairman, I'm Karl D. Bays, chairman of the board of Baxter Travenol Laboratories, the leading supplier of health care products, systems, and services. I'm also chairman of the board of the Health Industry Manufacturers Association (HIMA), and, in that capacity, I'm pleased to submit these comments on the extension of Medicare benefits to include catastrophic coverage.

## Introduction

HIMA represents over 300 manufacturers of medical devices, diagnostic products, and information systems. Member companies' products span medical technology, ranging from tongue depressors to life-saving surgical systems.

In our view, coverage of care for catastrophic illness is an issue affecting not just the future of Medicare but also the health of all Americans. The current debate has helped to improve general understanding of the problem; continued analysis will help in designing an approach offering Medicare beneficiaries more value -- the best possible protection at affordable costs.

In general, HIMA supports the extension of Medicare to include coverage for catastrophic expenses. We commend Secretary Bowen for his courage in this area and the administration for its endorsement.

Medicare beneficiaries have borne a heavier and heavier burden of out-of-pocket costs because of the program's current cost-sharing requirements for covered services and because of the increasing costs of non-covered services. Although 80 percent of Medicare beneficiaries today supplement their basic coverage either through MediGap policies or Medicaid, fewer than half (47%) of all beneficiaries have adequate coverage. In addition to the 20 percent who have no supplemental coverage, some 27 percent of all beneficiaries are inadequately covered by policies which are not affected by the minimum "MediGap" standards. Section 1882 of the Social Security Act -- commonly referred to as the Baucus amendments -- sets minimum standards for policies marketed as "MediGap".

Medicare beneficiaries face terrible confusion in trying to understand the gaps in the program's coverage and in figuring out whether their supplemental policies provide the necessary coverage. The many stories of Medicare beneficiaries who have multiple policies offering no additional protection highlight the need for better information and education -- a need that will be greater if a catastrophic benefit is enacted.

## Supplemental Coverage Under Consideration

The primary beneficiaries of the proposal you're considering are those who cannot afford private MediGap coverage and who, although poor, are ineligible for Medicaid. The proposal also would help those who are now paying for inadequate supplemental insurance not covered by the Baucus amendments -- either because the policy was written before 1980 or it is marketed under a name other than "MediGap".

## Beneficiary's Ability to Pay

HIMA's support of the expanded benefit includes the notion that the benefit would be self-funded. The simplicity of premium financing makes it an attractive option, but also one that should be viewed with some caution. Although the administration projected a $4.92 monthly premium for the first year, the Congressional Budget Office's estimates indicate that the premium in 1988 could be higher than $6.00 -- about one-fourth of the estimated 1988 monthly Part B premium. If this premium increased at all substantially in years ahead, it could become unbearable for those the program is intended to help. For that reason, HIMA urges the Committee to include in its analysis alternative funding approaches. Among them might be some form of relating financing to beneficiaries' income and ability to pay. HIMA is convinced that, over the long term, this will become an increasingly important element in financing Medicare expansions.

## Other Access Issues - Long-Term and Indigent Care

Our comments have been limited to Medicare coverage of catastrophic acute-care costs. Costs of long-term care are, however, a burden for most beneficiaries. Needs for long-term care are less understood, and the potentially huge cost of coverage makes a workable solution unlikely in the near future. The public and private sectors are just beginning to develop a variety of options for insuring and financing long-term care. Alternatives should be encouraged and evaluated. Knowledge of the problem must be widened and a solution must be found.

We also have not addressed the problem of the 37 million Americans who, for a variety of reasons, are not insured. HIMA believes that no single policy action is likely to solve that problem or the resulting increase in uncompensated care. Comprehensive, pluralistic reform, relying on public and private participation, will be needed.

## Conclusion

The current proposal extends coverage for some catastrophic expenses. It's an improvement but not a panacea. Significant coverage gaps will remain, both in acute and long-term care. Beneficiaries will continue to pay out-of-pocket costs for cost-sharing, for non-covered acute care services, and long-term care. Beneficiaries will continue to insure themselves with some form of MediGap coverage.

The proposal could result in significant confusion as beneficiaries decide whether to continue their supplemental policies or whether to self-insure up to the cap. As the MediGap industry responds to the new benefit by redesigning its products, Medicare beneficiaries will have new questions to answer and decisions to make.

A broad public information program involving government and the private sector will be a critical component of the new benefit.

HIMA appreciates the committee's attention to the catastrophic health care expenses now borne by Medicare beneficiaries. HIMA supports extended coverage for this expense and believes it will best be accomplished through a self-financing mechanism. When action on this is completed, then it is time to turn to the major outstanding issue of long-term care and the uninsured.

NATIONAL
ASSOCIATION
*of*
COUNTIES

*440 First St. NW, Washington, DC 20001*
*202/393-6226*

March 24, 1987

The Honorable
Senator Lloyd Bentsen
c/o William J. Wilkins
Staff Director
U. S. Senate Committee on Finance
205 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Senator Bentsen:

The National Association of Counties (NACo) appreciates the opportunity you have extended us to submit written testimony for inclusion of the record of your March 26th hearing on catastrophic health insurance. This is an issue which our Association has identified as one of its priorities for the current legislative session. We welcome the prospect of working with you and your staff in the development of a sound legislative package over the course of the next several months.

America's county governments are vitally concerned about the continuing rise in health care costs and the inability of an estimated 37 million of our citizens to obtain adequate third party coverage to meet those costs. As health care providers of last resort for the poor in our communities, county governments are financially liable for filling in the gaps in the social safety net. When private resources are lacking and insurance, Medicare and Medicaid do not pay the bills, we do.

Indigent care is a major responsibility of county governments today. We spend in excess of $25 billion each year to protect the health and safety of our constituents, and an increasing proportion of that investment is devoted to those who simply cannot meet their financial obligations for the health care services provided to them. Approximately 40% of the uncompensated care load in this country is borne by public hospitals.

Thus, to the extent that a national catastrophic health insurance plan is developed and implemented, to that extent some of the drain on the limited fiscal resources of counties will be relieved. If catastrophic insurance helps pick up the pieces for persons impoverished by medical calamity, counties will be freed to devote their health care resources elsewhere, strengthening budgets for prevention, health education, immunization, nutrition and other programs which have been necessarily slighted because of the priority given to those who need care but cannot afford it.

NACo applauds the various proposals now before the Congress as important steps in the right direction. But our Association believes that acute, episodic hospital-based catastrophic insurance does not go far enough toward meeting the broader constellation of populations at risk which merit consideration. The Bowen plan and its derivatives define an essential core of coverage, but it is estimated that only 3% of the elderly population will derive any benefit from an acute, episodic hospital-based approach.

County officials are concerned about a much larger population of uninsurables and individuals who may be compelled to "spend down" to poverty to cover their medical bills. The chronically mentally ill, AIDS victims, families with infants in neonatal intensive care, the disabled, and persons in long term care all face catastrophic health care costs which should be embraced in the design of a national plan.

At NACo's recent Legislative Conference, our Association adopted a resolution calling for comprehensive catastrophic insurance coverage. A copy is attached and we commend it to your attention. We believe that, even if fiscal constraints prevent you from broadening immediate coverage, implementing legislation should be staged to phase-in new populations at risk as part of a clearly defined agenda of reform. We recognize that there are significant costs to a comprehensive approach, but would assert that the current neglect and inaction have their price as well. Society is already paying for catastrophic health care costs in far less direct and desirable ways.

The National Association of Counties earnestly solicits your consideration of an expanded and comprehensive catastrophic health insurance package. We stand ready to support your efforts in that direction.

Sincerely,

John Horsley
President

# HEALTH & EDUCATION STEERING COMMITTEE
# RESOLUTION ON
# CATASTROPHIC INSURANCE

**WHEREAS**, The Congress is currently considering several alternatives to assist families and individuals who have incurred excessive health care costs of catastrophic proportions; and

**WHEREAS**, the Department of Health and Human Services estimates that at least 2.8 million Americans pay $5,000 or more in out-of-pocket costs for health care, after insurance coverage, and that these individuals can be found in all age groups, race, and geographic regions of the country; and

**WHEREAS**, persons liable for catastrophic health care costs may be forced into poverty, spending their life savings and assets to repay medical bills; and

**WHEREAS**, those who should be the beneficiaries of the wonders of medicine and the compassionate hand of the healer too often become the victims of essential, life-maintaining services they cannot afford, creating stresses which fracture family stability and add to the social problems confronting society; and

**WHEREAS**, county governments are legally liable as the providers of last resort for those whose resources cannot match the expenses incurred by catastrophic illness and are compelled to seek relief through uncompensated charity care or county reimbursement; and

**WHEREAS**, county governments have both a humanitarian concern for the health and well-being of their constituents and a justifiable fear that local public resources may be unable to meet the rapidly increasing demand for financial support of catastrophic medical costs uncovered by traditional insurance and beyond the means of those impoverished by such costs;

**THEREFORE BE IT RESOLVED**, that the National Association of Counties strongly urges the Congress to enact a national catastrophic health insurance program which will limit out-of-pocket expenses for health care given by physicians and other health care providers, hospital services, and long term care; and

**BE IT FURTHER RESOLVED**, that a comprehensive, national catastrophic health care insurance plan recognize that the Federal Government must play an active and major role in the financing of such a plan, but that the private and state and local governments can contribute their fair share to the resolution of immense personal and social problems arising from catastrophic illnesses; that a true partnership must be forged between all levels of government, the private sector, and providers and employers to assure equitable relief for all persons who incur extraordinary health care costs; and

**BE IT FURTHER RESOLVED**, that a phased-in approach to a comprehensive national catastrophic health insurance plan may be necessary in lieu of immediate implementation of all segments, but legislation should clearly identify the staging of a phasing-in process of future expansion to a comprehensive level of coverage for all Americans.

Passed by Health & Education Steering Committee
March 15, 1987 (unanimous)

**National Association of Medical Directors of Respiratory Care**

P.O. Box 7011
Arlington, VA 22207
(703) 527-1032

Alan L. Plummer, M.D.
President

# THE NATIONAL ASSOCIATION OF
# MEDICAL DIRECTORS OF RESPIRATORY CARE

## STATEMENT FOR THE RECORD

## COMMITTEE ON FINANCE
## UNITED STATES SENATE

## CATASTROPHIC HEALTH INSURANCE

Submitted March 31, 1987

The National Association of Medical Directors of Respiratory Care (NAMDRC) is a professional organization composed of physicians who serve as medical directors of respiratory care programs in over 2000 hospitals nationwide. Eightyfive percent of our membership is composed of internists and pulmonologists, and anesthesiologists account for 12% of our members.

NAMDRC supports the goal of catastrophic health insurance and, as many others, we see it as but one step toward addressing the complex issues surrounding long term care. The proposed approach of expanding the acute care benefits for Medicare beneficiaries is encouraging and we support it. Likewise, NAMDRC views the proposed payment methodology, a modest increase in the Part B premium, as a logical approach to fund the program through contributions of those most likely to benefit from it.

NAMDRC does have, however, one serious reservation about the program as we understand its likely implementation. If indeed the Congress hopes to expand the beneficiary's length of hospital stay from the current maximum of 150 days to 365 days, and if the payment mechanism for such an approach is a simple expansion of outlier payments, we fear that such a plan will not come close to meeting the costs that hospitals will incur.

NAMDRC began detailed research on this subject nearly two years ago when we attempted to examine the variable costs of maintaining ventilator patients in the hospital for extended periods of time. These results have been published under the title "Financial Implications of Prolonged Ventilator Care of

Medicare Patients under the Prospective Payment System" in the March, 1987 issue of Chest, published by the American College of Chest Physicians.

A brief review of the data shows that Medicare beneficiaries who were mechanically ventilated for at least 48 hours incurred hospital costs significantly beyond reimbursement. These costs, averaging over $21,000 beyond Medicare reimbursement, far outweighed any amount that a hospital could have received for so called low-end DRGs. Therefore, it is clear that hospitals have a financial incentive not to use a particular life sustaining technology.

There is growing recognition by health policymakers from the Congress and the Administration that the outlier program does not adequately reimburse for intensity of care. A plan to expand such an inadequate program only exacerbates a problem rather than solving it.

As a solution, NAMDRC strongly urges Congress to address the issue of intensity of care prior to any significant expansion of the outlier program. We also suggest two possible solutions that could be used to address the intensity of care problem concerning patients who require mechanical ventilation for 48 hours or longer:

1. Establish a multiplier factor for this group of patients. Use it to multiply the DRG payment by the specified amount. For example, let's say that mechanically ventilated

patients historically have costs eight times beyond those of non-ventilated patients. Reimbursement for these patients would be calculated by multiplying the appropriate DRG payment by eight.

The need for mechanical ventilation is well accepted within defined medical criteria, so that the chance of abuse beyond these criteria is slim. With a little effort PROs could have solid review criteria for such cases which, legitimately, should undergo initial review.

2. Establish a new DRG. The current system simply does not adequately address the costs incurred by a hospital when a Medicare beneficiary is mechanically ventilated for 48 hours or longer.

All patients who require mechanical ventilation for 48 hours or longer would be transferred to this new DRG regardless of the principal diagnosis and the relative weight of this new DRG should reflect the costs of the resources used with these patients. HCFA should have the cost data available to move in this direction.

Again, NAMDRC commends the Committee for addressing catastrophic health costs. We simply urge you to act wisely and prudently, and most certainly request that you not discriminate against those patients who are most likely to incur catastrophic costs.

R

**March 26, 1987**

Edward R. Roybal
**EDWARD R. ROYBAL**
**Chairman, House Select Committee on Aging**

## TESTIMONY ON CATASTROPHIC HEALTH CARE LEGISLATION BEFORE THE COMMITTEE ON FINANCE

### Washington, D.C.

Chairman Bentsen and Subcommittee Chairman Mitchell. As you may know, I have frequently stated my fear that this year's catastrophic health care bill will fail to fill Medicare and Medicaid's real gaps or to solve the full problem of the 37 million uninsured and the 200 million underinsured. However, I also understand the desire to pass some type of limited and less costly catastrophic health care legislation quickly.

In response to those who have asked for a more limited catastrophic health package than my more comprehensive "USHealth" Act, I am about to introduce the following catastrophic health initiative (CHI) -- **the Medicare and Medicaid Catastrophic Acute and Transitional Care Act — which includes a "Federal Medigap Insurance (FMI)" plan and increased Medicaid protection.** (See attachment.) Though this type of catastrophic proposal is a first step toward catastrophic protection and better protects the children, elderly and disabled, we must be mindful of its limitations. That is, **it does not fill most of the real gaps in Medicare, it does not solve the long term care problem and it does not protect most uninsured.**

Given its limitations, you might ask why I am introducing this particular package. Very simply, many members, including myself, expressed their desire to provide more protection than the package offered by the Administration. However, these members also indicated that they felt they could not go as far this year as the more comprehensive proposals offered by myself and others. I believe that this package, at a price tag of about $15 billion, fills that void.

What improvements does this catastrophic health initiative (CHI) make on the Administration proposal? They include the following:

**MEDICARE: (Federal Medigap Insurance (FMI))**
* Lowers the catastrophic cost limit from $2000 down to $500 and better protects lower and middle income beneficiaries.
* Adds a catastrophic prescription drug benefit with cost controls.
* Strengthens Medicare's transitional care package by removing the three day prior-hospitalization prerequisite to nursing home care, relaxing the definition of skilled nursing home care and home health care and thus increasing access, and better defining home health intermittent and homebound requirements.
* Adds a limited and flexible respite care benefit.
* Uses a fairer financing mechanism that is less regressive than a straight premium and that avoids taxing the value of current Medicare benefits.

**MEDICAID:**
* Adds coverage for more near poor women and infants.
* Adds coverage for more poor children.
* Improves spousal income and asset protection and raises personal needs allowance for nursing home residents.
* Adds first dollar coverage for elderly and disabled's Medicare cost-sharing.

I believe that this catastrophic health initiative (CHI) provides important, limited catastrophic protection for Medicare and Medicaid beneficiaries without having to tax existing Medicare benefits or increase the deficit. This package incorporates the strengths of the Administration and Stark/Gradison proposals while providing better protection, especially for lower income elderly and nonelderly. Its total cost of about $15 billion is not only affordable, but **most of the costs for the new Federal Medigap Insurance will be paid by the elderly and by disabled Medicare beneficiaries themselves.**

# ROYBAL CATASTROPHIC HEALTH INITIATIVE (CHI), THE "MEDICARE AND MEDICAID CATASTROPHIC ACUTE AND TRANSITIONAL CARE ACT" — H.R. 1930

## MEDICARE PROVISIONS (Federal Medigap Insurance):

1) **A $500 catastrophic limit is placed on beneficiary out-of-pocket costs** resulting from any Medicare Part A and B coinsurance/deductibles (including prescription drugs, transitional care, and respite care) and is indexed to increases in the Medicare Part A and Part B per capita costs. (Start-up date: January 1, 1989.)

2) **Prescription drugs are added as a benefit** subject to a $300 deductible and a coinsurance of $2 per prescription and subject to the above catastrophic limit. The DHHS Secretary shall design the prescription drug benefit program so that drugs are purchased from participating pharmacies only and prescription drug prices are prospectively set by Medicare. (Start-up date: January 1, 1990.)

3) The following changes are made in hospital coinsurance and deductible: (Start-up date: January 1, 1989.)

   a. There would **no longer be any hospital coinsurance except for one deductible per calendar year.**

   b. The **hospital deductible is indexed to the percentage increase in the Social Security COLA.**

4) Transitional care is strengthened by the following changes in nursing home and home health care:

   a. **The skilled nursing (extended care) home benefit is redefined** as follows:

      - **The three day prior-hospitalization requirement for skilled nursing home care is dropped.** (Start-up date: January 1, 1989.)
      - **Skilled nursing facility care is increased to cover up to 150 days.** (Start-up date: January 1, 1989.)
      - **Nursing home coinsurance is reduced to 1/5th of nursing home costs** (based on the national average per diem Medicare reasonable cost for SNF services) and **is applied only to the first seven days.** (Start-up date: January 1, 1989.)
      - **The definition of "skilled nursing home care" is refined** to allow better access to skilled nursing care by: 1) defining, as eligible, skilled nursing services required on a regular, but not necessarily daily basis, as certified by a physician; 2) making explicit that skilled nursing services include physical therapy and rehabilitative services needed on a regular basis to preserve or restore functional capabilities or to prevent further deterioration, including the training of patients and caregivers in rehabilitative techniques; 3) making explicit that, in determining eligibility for skilled nursing services, "practical matter" considerations be included regarding a) the availability of home support and b) the lack of Medicare coverage for home health services that are certified by a physician as being medically necessary. (Start-up date: January 1, 1990.)

b. **The home health benefit is redefined** as follows:
   - Home health care is defined as "intermittent care" including 1) up to one or more home health visits per day up to 7 days a week for up to 90 days a year and thereafter, under exceptional circumstances, as certified by a physician, and 2) home health visits at a frequency of less than 7 days per week for an unlimited period of time as certified by a physician. (Start-up date: January 1, 1989.)
   - "Homebound" is clarified as a situation where there is a normal inability to leave home and, consequently, to leave home would require a considerable and taxing effort. Occasional absences from the home are permitted for medical or non-medical purposes. (Start-up date: January 1, 1989.)
   - The definition of home health care is refined to include: 1) on a physician's prescription, such personal support services as needed on a short term basis to offset problems of limited home support that would otherwise preclude beneficiaries from receiving home health services for which they are eligible; 2) on physician prescription, such short term rehabilitative services as needed on a regular basis to preserve or restore functional capabilities or to prevent further deterioration, including the training of patients and caregivers in rehabilitative techniques. (Start-up date: January 1, 1990.)

c. **Plans of care are required,** as condition of participation under Medicare, for all patients needing transitional care and respite services and are required of all providers (including primary care physicians, hospitals, nursing homes, HMOs, home health agencies, hospices). The plan of care is to include an assessment of patient needs, the services to be provided and the provisions for discharge. The plan of care is to be prepared, implemented and periodically review and updated through consultation among appropriate providers including physicians, nurses and social workers, and are to be signed by a physician. PROs are to oversee quality and effectiveness of plans of care. (Start-up date: January 1, 1989.)

d. Demonstration projects are to be carried out on "managed care" approaches to providing transitional nursing home, home health and respite care services including 1) approaches similar to the Medicaid Home and Community Based Services Waiver Program, and 2) the full range of nursing home, home health, and respite care services as provided by this Act. (Start-up date: July 1, 1988.)

5. **The DHHS Secretary is required to develop and implement respite care as a new benefit when prescribed by a physician.** The respite care benefit shall, at the beneficiary's choice, cover up to 10 days of nursing home care per year (based on the national average per diem Medicare reimbursed cost for SNF services) or the equivalent dollar value of hospital-based respite care, adult day health care, or in-home care. A 50% co-insurance is required up to the catastrophic limit. (Start-up date: January 1, 1990.)

6. **The hospice benefit is extended** beyond the current 210 day limit if the patient is recertified as terminally ill. (Start-up date: January 1, 1989.)

7. Enrollment in the FMI package is automatic for Medicare beneficiaries enrolled in Medicare Part B.

8. **Financing for the FMI package comes from the following sources:**
   - a. **One-half of the revenues from raising the cigarette tax by 16¢ and indexing the tax to the Consumer Price Index. (Start-up date: January 1, 1989.)**
   - b. **An initial FMI premium of $10 per month which is indexed to increases in the cost of the Social Security COLA. (Start-up date: January 1, 1989.).**
   - c. **The remaining expanded benefit package is financed by the elderly through a special add-on tax on elderly income which is not a tax on the actuarial value of Medicare. This special add-on tax on people age 65 and over is applied as a percentage of taxable income and is set at a level (rounded up to the next highest one-half of one percent) actuarially sufficient to cover the cost of the FMI package less the cigarette tax and premium financing. (Start-up date: January 1, 1989.)**

## MEDICAID PROVISIONS:

1. **States are given the option under Medicaid to a) extend coverage for pregnant women and infants up to age one regardless of family composition with incomes up to 185 percent of the Federal poverty level and b) accelerate coverage of children up to age 5 who are under the Federal poverty level. Continued Medicaid coverage is mandated for children who are on Medicaid but go past the age 5 limit.** (This proposal was introduced by Representative Waxman as H.R. 1018.)

2. **Medicaid coverage is mandated for all children under age 18 (and 18 to 21 year olds in school, jobs, or job training) with family incomes/resources under the state poverty level.**

3. **States are given the option under Medicaid to cover any child under age 21 with family income below the federal poverty level but over the AFDC level.**

4. **Medicaid coverage is mandated for all children under age 5 who have family incomes below the federal poverty level.**

5. **States are required to cover Medicare Part B premiums and cost-sharing on behalf of their elderly and disabled Medicaid recipients.**

6. **Medicaid institutes a spousal protection plan** protecting limited amounts of income and assets when one member of an elderly couple is placed in a nursing home and is covered by Medicaid (Note: This proposal was introduced by Representative Waxman in H.R. 1711.)

7. **The Personal Needs Allowance is raised from $25 to $35 per month.** Before the additional money is made available, the Secretary is required to take the necessary steps to ensure that the additional funds be used only for the personal use of the patient and not to pay for any nursing home related costs.

8. **Financing for the Medicaid package comes from the following sources:**
   - a. **Federal Medicaid savings resulting from Medicaid's buy-in to the FMI package.**
   - b. **One-half of the revenues from raising the cigarette tax by 16¢ and indexing the tax to the Consumer Price Index. Funding from the raised and indexed cigarette tax will be used to offset the added Federal costs of this Medicaid package less any Federal savings resulting from the Medicaid buy-in. Any cigarette tax funds not used to fund the Federal costs of this Medicaid package are to be made available to the States for their Medicaid programs.**

**NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE**

1300 19th Street, N.W., Suite 501, Washington, D.C. 20036 (202) 822-9459

# STATEMENT OF

FORMER CONGRESSMAN JAMES ROOSEVELT
CHAIRMAN OF THE NATIONAL COMMITTEE
TO PRESERVE SOCIAL SECURITY AND MEDICARE

SUBMITTED TO
COMMITTEE ON FINANCE
U.S. SENATE

REGARDING
CATASTROPHIC HEALTH INSURANCE

MARCH 26, 1987

I am James Roosevelt, Chairman of the National Committee to Preserve Social Security and Medicare. In that capacity, I represent more than four million members, for most of whom Medicare is the primary health insurance protection. For far too many of them, those with low income and little or no other resources, Medicare is their only health insurance coverage. I commend you, Mr. Chairman, for holding these hearings to search for solutions to overcome the financial tragedy that a catastrophic illness can cause older Americans. Your concern about this issue is deeply appreciated.

It is not an exaggeration to say that Medicare has made the difference between life and death for countless thousands of seniors who might otherwise have delayed seeking care until a once treatable condition had become life-threatening. As vital as it is, however, Medicare does not cover a full range of medically necessary services. Sadly, thousands of individuals and families are reduced to poverty when illness strikes. To be forced into bankruptcy because of unmanageable health care costs is a true catastrophe. Protection against such catastrophic expenses is Medicare's unfinished business.

Mr. Chairman, as you know, this Congress is about to make a very important decision. Will Congress decide to tinker with the current Medicare system or will Congress take the bold step of comprehensive reform and expand Medicare to cover long-term care and prescription drugs? The President proposes a very limited expansion of Medicare to protect seniors against catastrophic hospital and doctor costs. Legislation introduced by key members of the House Ways and Means Committee, while better than the President's proposal, is similar in scope. However, an important bill has been introduced by Senator James Sasser (S. 454) which includes catastrophic coverage for long-term care as well as preventive exams, vision, dental and hearing care. Representative Pepper has introduced a similar bill, H.R. 65, in the House, which includes prescription drugs. We want to commend Senator Sasser for the leadership he has shown by sponsoring legislation which would bring such important coverage for seniors. We hope this Committee will consider S 454 and include prescription drugs under Medicare coverage.

Assuring quality health care to all citizens who require nursing home care or extended home care or who depend on drug therapy certainly represents an important financial commitment. The National Committee fully appreciates the challenge you face. Yet we agree with Representative Pepper when he says that we cannot afford NOT to cover long-term catastrophic health care costs. This may well be the historic time to search our conscience and our coffers to come up with a solution.

## A LIMITED PROPOSAL

President Reagan's proposal falls short of providing true catastrophic Medicare protection. Medicare beneficiaries face the catastrophe of bankruptcy because Medicare pays for less than half of the health care of seniors. Under the President's proposal, Medicare would pay for Medicare covered hospital and doctor expenses above $2,000. However, most people will already have spent a lot more for uncovered expenses such as nonassigned doctor fees or prescription drugs. Many individuals suffering from chronic illnesses, such as Alzheimer's disease or arthritis, do not need doctor and hospital care. They are more likely to incur catastrophic expenses related to nursing home care, home health care and/or prescription drug expenses. The President's proposal would not help these victims.

Among the thousands of letters received each week by the National Committee to Preserve Social Security and Medicare are numerous pleas for help with health care costs. Some have unpaid medical bills which often total more than two or three years' income. Many individuals and families are confronted with total impoverishment when bills for acute or chronic care reach catastrophic proportions. It is no wonder that many seniors and their families are concerned for the future.

I recently received a letter from a National Committee member from Knoxville, Tennessee. This women's story is a tragic reflection of the inadequacy of Medicare's current coverage:

> I am writing to tell you about my husband. Henry has been in the hospital for 23 days. My son had to put him in a nursing home today... He has been bad for over a year. He has had two strokes. I have waited on him and me sick. See, I live by a pacemaker and can hardly walk because of arthritis. The doctor said I could no longer care for him because I coundn't lift him or give a bath or give him IVs so he had to go to a nursing home... We are both 74 years old and I feel God has been good to us both. He worked until he was 70 years and paid in Social Security ever since 1937. He sure wasn't lazy.... All of our life savings are gone now. Henry and I together got $831 Social Security. They (the nursing home) will take $562 of his and that will leave me $269 to live on, which sure will be rough going, me with this sickness I have. My medicine really costs ($80 a month). I'm going to try to get SSI and Medicaid, food stamps. My pacemaker check on the phone is $30 a month.

President Reagan's legislation would not help this couple pay for his care in the nursing home or for her prescription drugs. She might have been able to keep her husband at home if she had some physical assistance. After a lifetime of work and saving, this woman will now be permanently dependent on public assistance. In fact, the President proposes to help only 800,000 seniors a year or about 3 percent. It will more likely upset the other 97 percent to pay $60 a year more in premiums yet receive no additional benefit. Clearly, it is politically dangerous to offer such a limited proposal. Seniors expect greater vision and more tangible results.

## COMPREHENSIVE CATASTROPHIC MEDICARE COVERAGE

At the beginning of this century, the most prevalent health problems of seniors were acute. Today, the most prevalent health problems are chronic, and the likelihood of having a chronic or disabling condition increases dramatically with age. An estimated 85 percent of Americans are underinsured against the catastrophe of long-term care. And few have insurance for prescription drugs.

Nursing home care. Probably the greatest fear held by older persons is to become so totally disabled that they must enter a nursing home for an extended period of time. Although only about five percent of the elderly live in nursing homes at any given time, about 20 percent of the very old are institutionalized. The fear of having to live a dependent life in an institutional setting is coupled with the enormity of the expense and drain on resources. The average person will deplete his or her resources in little more than three months at the rate of about $22,000 a year for nursing home care.

The misconception that Medicare covers nursing home care is still all too prevelent. Yet Medicare covers only two percent and private insurance just one percent of this nation's nursing home bill. While many older Americans are under the illusion that they are protected by Medicare and Medigap insurance, the devastating reality is that only after spending themselves into poverty does the public step in to help. Medicaid covers nursing home care for impoverished patients - the last resort for many families who must suffer the humility of seing their dependents supported by a welfare program.

Community-based care. Since the beginning of Medicare and Medicaid, public policy has been more directed to support of institutional care than community-based care. As important as is coverage of nursing home stays, it is equally important that any new catastrophic legislation not be biased toward institutional care. For every one frail person in an institution there are two equally frail people being cared for in the community. In addition to the very frail, many more seniors require some type of assistance with activities of daily living. Most are cared for informally by families, others by a combination of informal and formal support services. New policy should encourage community-based care by increasing support to families caring for their dependents.

For seniors themselves, home care has always been the preferred care, whenever possible. Families respond to this preference by performing 80 to 90 percent of the care given their dependent relatives. Still, there is a great need for formal home care services to complement family care. Our nation has a serious problem with home care. Medicare covers only limited, acute skilled nursing care, while coverage for homemaker and chore services is virtually non-existent.

The demand for home care has increased by 37 percent since the Medicare Prospective Payment System for hospitals was implemented in 1983. Yet Medicare is increasingly denying coverage for home health services. The General Accounting Office recently found that 86 percent of hospital discharge planners reported problems with home health care placements. Under an expanded health care system, home care should be made available through a comprehensive needs assessment and a care management system.

Adult day care is another important element in the continuum of care necessary to meet the growing need of aging members of our society. Only within the last decade has this type of custodial care gained acceptance. We currently have an estimated 1,000 adult day care centers in the United States providing service to between 10,000 and 15,000 disabled adults.

A recent study by the National Council on the Aging found the average participant of an adult day care center to be a 73 year old female living on a $478 a month income. She is living with family or friends. Half of the participants need supervision, one out of five have difficulty walking, and about one out of eight is wheelchair-bound. The average charge per day is $22. The indication is that adult day care participants are mentally or physically frail. While the participant receives both care and socialization, the family members receive respite from the stresses of providing care to a frail person. Adult day care can provide a place to bring the dependent family member from a few hours a week to enough hours to enable the caregiver to work in a job outside the home. With this type of support, the family is able to provide care longer and, therefore, postpone or prevent institutionalization.

Prescription drugs. Another example of the inadequacy of Medicare's coverage is the failure to pay for prescription drugs. For some older people, chronic, long-term care consists of taking the appropriate prescription drug. However, these prescriptions can be very expensive. It is not unusual for a person with a heart condition to spend more than $100 per month on medications needed to sustain life. Diabetes is another example of a chronic health problem which requires careful monitoring and access to insulin. If a diabetic cannot afford insulin, Medicare may eventually have to pay to amputate his or her leg. This individual may also end up in need of nursing home care -- thousands of dollars spent because a few pennies were "saved."

The heaviest use of prescription drugs is, understandably, among the older population. Older Americans are 2 1/2 times more likely to be taking three or more prescription drugs regularly than younger adults. Most seniors, an estimated two-thirds, take at least one prescription drug at any one time, and many take as many as four or five drugs a day. Unfortunately, Medicare covers only drugs used while the person is hospitalized or in a skilled nursing facility. Medicaid will only cover the costs of prescription drugs for the poor. Payments for drugs represent 20 percent of senior citizens' total out-of-pocket health care costs and average $340 per person per year.

## FINANCING

Despite the desire of policy makers to protect Americans from the cost of a catastrophic illness, the Pepper/Sasser legislation is one of the few to have made a proposal on a scale sufficient to solve the problem. In an era of large government deficits, most worry that the American people would not support a new, costly government commitment. But this argument ignores the fact that the American people already pay for catastrophic illness.

Seniors and their families pay almost as much of their health care bill as Medicare, but only about one quarter through insurance premiums. The majority of private expense is in the form of Medicare copayments and uncovered expenses. Medicaid and other government programs pay for about 10 percent, mostly for nursing home care. If Medicare paid for catastrophic illness for seniors, Medicaid's resources devoted to senior citizens could be shifted to Medicare. Most seniors and their families could afford to contribute more to Medicare through premiums and taxes if they in turn received more comprehensive health insurance.

A major limitation to comprehensive catastrophic legislation is the shortsighted approach to financing. Some Members of Congress have expressed opposition to any proposal which is not "generationally neutral." They apparently mean that older Americans alone should share in the cost of expanding Medicare to provide additional services and that it is "unfair" for the working population to participate in the financing. Both the President and the Ways and Means Health Subcommittee impose additional premiums or taxes only on seniors to finance new Medicare coverage. This financing limitation ignores the fact that the problem of catastrophic health care costs for seniors is not generationally neutral.

Generations are interrelated and families do take care of their dependent relatives. Consequently, the pleasure and the burden of caring for individuals at the end of the life span is one that we all share. Family members help each other financially, physically and emotionally. The whole family, young as well as old, has a vested interest in knowing that fathers, mothers, grandfathers and grandmothers are being well cared for in their old age. It makes more sense to share the financial responsibility through a catastrophic insurance program than through the inefficient and dehumanizing method of bankruptcy and welfare.

By the time of retirement, individuals no longer have the resources to be able to finance all their health care. The financing of Medicare must begin while working. This is the overall principle for currrent Medicare financing. A young worker with a family, try as he might, will find it difficult to save for his health care protection when retired. And to expect seniors to pay for the full cost of health care will not solve the problem of catastrophic illness, but will continue to foster the problem.

Most senior organizations and some Members of Congress refuse to step forward and lead on the issue of financing. Senator Sasser and Representative Pepper are not afraid and neither is the National Committee. We endorse the financing proposals in the Pepper/Sasser bill to transfer some Medicaid resources to Medicare and to add additional contributions from beneficiaries. The National Committee also believes that it is necessary to control open-ended costs through health care delivery reform. The Pepper/Sasser bill proposes a capitation approach. Considering the Administration's interest in capitation, it is perhaps surprising that the President did not adopt the Pepper/Sasser approach to providing catastrophic care.

According to a preliminary Congressional Budget Office estimate, the cost of the Pepper/Sasser bill including prescription drug coverage would be about $65 billion a year. The National Committee proposes that seniors pay for approximately half of the cost of a comprehensive Medicare catastrophic package through premiums, deductibles and copayments. Seniors should finance the majority of their share through a premium.

Rather than deducting a flat amount from a Social Security benefit, however, the National Committee recommends a premium that is a percentage of the Social Security benefit. This would insure that all pay a fair share, but not more than they can afford. This financing mechanism is similar in principle to the payroll tax which is a percentage of earnings. If next year's $22.30 monthly premium was replaced by a premium equal to 15 percent of the Social Security benefit of Medicare eligible individuals, Medicare revenues would increase by over $20 billion. The average retired worker would pay about $73 a month (15 percent of $488), a little more than three times next year's projected premium.

Senior citizens currently pay about $40 billion a year out-of-pocket for Medicare deductibles and copayments and uncovered health care expenses. The National Committee recommends that Medicare cover all health care expenses and that Congress develop a deductible and copayment package that would reduce out-of-pocket liabilities by one-third to $10 to $15 billion a year. With a slightly higher premium, deductibles and copayments could be even less. Deductibles and copayments should be spread over hospital, doctor, nursing home, community-based care and prescription drug costs with an overall ceiling on out-of-pocket costs. Under this financing package, deductibles and copayments would average about $333 a year. Private insurers would probably be anxious to capture a $10 to $15 billion market and would consequently provide insurance packages to cover these deductibles and copayments.

Even assuming a 10 percent saving from health care delivery reform, the financing package does not come together without additional contributions from the whole population. The National Committee supports raising the Medicare payroll tax rate. Raising the tax rate from 1.45 percent to 1.6 percent would raise approximately $6 billion a year. Eliminating the wage base for Medicare payroll taxes, as the Pepper bill proposes, would raise an additional $7 billion a year. The National Committee is not opposed to increases in Medicare payroll tax revenues. However, we would also recommend the development of additional financing sources for Medicare that are more progressive and less a disincentive to employment. One suggestion is earmarking income tax revenues for Medicare. A one percent earmarked tax on all taxable income, for example, would raise about $19 billion a year. To the extent that seniors worked or had taxable income, they would also contribute through the payroll tax and earmarked income tax.

## SUMMARY

Of all the legislation introduced to date, the National Committee believes that the best starting point for developing a Medicare catastrophic health insurance plan is the legislation introduced by Senator Sasser and Representative Pepper. This legislation offers the most comprehensive coverage.

Clearly we need to assure senior citizens access to a full range of health care services, including long-term care in a nursing home and prescription drugs. The financing of a Medicare catastrophic health insurance plan will undoubtedly be controversial. At the same time, financing is at the heart of the debate. Without additional financing, comprehensive Medicare catastrophic coverage will remain a fantasy. The National Committee hopes its financing proposals can be a catalyst for further debate and action on an agenda of vital importance for all Americans. It is time that we meet the challenge head on.

Before concluding, I would like to acknowledge the legislative contribution of other Members of Congress, who have made worthwhile proposals to expand Medicare or to ameliorate strict limitations on Medicaid eligibility for nursing home care. The details of some of these proposals should be incorporated into more comprehensive legislation. If action is not taken this year on a more comprehensive proposal, we would expect Congress to act on at least some of the proposals to:

* clarify eligibility requirements for Medicare home health care
* expand eligibility for community-based care under Medicare
* cover prescription drugs under Medicare
* prevent spousal impoverishment
* eliminate the requirement for 3-day prior hospitalization before coverage of skilled nursing care
* increase Medicaid nursing home personal allowance from $25 to $35
* cover adult day care under Medicare
* cover preventive examinations

This country spends 11 percent of its gross national product on medical care -- more than any other industrialized nation. Yet in comparison with other industrialized nations, we fall sadly short of providing comprehensive health care for our citizens. Because of the limitations of our health care financing, many seniors live with the constant threat of bankruptcy in the face of serious or long-term disability. Let this be the Congress which has the courage and the vision to provide affordable and adequate health care coverage to older Americans faced with a catastrophic illness. To do so would banish the fear of financial hardship from the lives of countless Americans.

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TESTIMONY OF

FRANCIS R. CARROLL

PRESIDENT

SMALL BUSINESS SERVICE BUREAU, INC.

ON MANDATED HEALTH INSURANCE BENEFITS

PREPARED FOR THE

U.S. SENATE FINANCE COMMITTEE

A Big PLUS for small business success!

MR. CHAIRMAN, I WANT TO THANK YOU FOR THE OPPORTUNITY TO ADDRESS THE COMMITTEE ON THE ISSUE OF GOVERNMENT INVOLVEMENT IN HEALTH INSURANCE COVERAGE. MY NAME IS FRANCIS R. CARROLL AND I AM PRESIDENT OF THE SMALL BUSINESS SERVICE BUREAU, INC. (SBSB), AN ORGANIZATION REPRESENTING OVER 35,000 SMALL BUSINESSES WHICH ARE "MOM AND POP" COMPANIES FROM ACROSS THE COUNTRY. I AM ALSO A MEMBER OF THE ADVISORY COUNCIL TO THE U.S. SENATE SMALL BUSINESS COMMITTEE.

THE NUMBER ONE ISSUE FACING SMALL BUSINESS OWNERS TODAY IS ACCESS TO QUALITY, AFFORDABLE HEALTH CARE FOR THEMSELVES AND THEIR EMPLOYEES. THERE ARE SEVERAL PROPOSALS BEING CONSIDERED BY CONGRESS WHICH WILL DETERMINE THE FUTURE DIRECTION OF THIS COUNTRY'S HEALTH CARE SYSTEM. WE HAVE REACHED A CROSSROAD REGARDING HEALTH CARE POLICY IN AMERICA. CATASTROPHIC HEALTH COVERAGE AND UNIVERSAL ACCESS TO HEALTH CARE SERVICES ARE ISSUES WHICH WILL HAVE A PROFOUND IMPACT ON ALL HEALTH CARE CONSUMERS AND ESPECIALLY THE SMALL BUSINESS COMMUNITY.

FOR NEARLY 20 YEARS NOW, THE SMALL BUSINESS SERVICE BUREAU HAS BEEN ACTIVELY INVOLVED IN HEALTH CARE AND COST CONTAINMENT ISSUES AT THE STATE AND FEDERAL LEVELS OF GOVERNMENT. ADDRESSING THESE CONCERNS POSES A MAJOR CHALLENGE TO THE PUBLIC AND PRIVATE SECTOR. THE GROUNDSWELL OF SUPPORT FOR LEGISLATION IS A CALL FOR CONGRESS AND THE BUSINESS COMMUNITY TO COOPERATE IN DEVELOPING POLICIES WHICH WILL BE AFFORDABLE, EQUITABLE, AND WHICH WILL ENCOURAGE PRIVATE SECTOR PARTICIPATION.

WITH THIS IN MIND, PLEASE CONSIDER THAT IF CONGRESS VOTES TO MANDATE HEALTH INSURANCE BENEFITS FOR SMALL BUSINESSES, THE

EFFECTS ON THE NATION'S ECONOMY CANNOT BE UNDERESTIMATED. I WOULD THEREFORE LIKE TO SUGGEST OPTIONS TO MAKE THESE MANDATES MORE ACCEPTABLE AND AFFORDABLE TO SMALL BUSINESS.

WHILE SMALL BUSINESSES IN AMERICA GENERATE MOST OF THE NEW JOBS IN THE ECONOMY, THEY ARE THE LEAST ABLE TO AFFORD TO OFFER EMPLOYEE BENEFITS. CONSIDERING THAT 80 PERCENT OF AMERICAN PROPRIETORSHIPS HAVE SALES OF LESS THAN $50,000 ANNUALLY, AND PAY AS MUCH AS 200 PERCENT MORE FOR COVERAGE THAN EMPLOYEES OF LARGE COMPANIES, THIS IS NOT SURPRISING. WITH THESE STATISTICS IN MIND, THE CHALLENGE BEFORE US IS TO PROVIDE THE PROTECTION THE OWNERS, OPERATORS AND EMPLOYEES OF SMALL BUSINESSES NEED WITHOUT CRIPPLING THE VITALITY OF THIS IMPORTANT SECTOR OF OUR ECONOMY.

THE WORD "MANDATED" HAS TRADITIONALLY BEEN A RED FLAG FOR SMALL BUSINESS OWNERS. BUT SBSB MEMBERS NOW REALIZE THAT THE TIME HAS COME TO FACE THE HEALTH CARE CRISIS AND RESPOND TO FEDERAL INITIATIVES WITH CONSTRUCTIVE IDEAS INSTEAD OF REACTIONARY CRITICISM.

IF THE CONGRESS MANDATES HEALTH CARE COVERAGE WITHOUT ADDRESSING THE UNDERLYING PROBLEMS OF ACCESSIBILITY AND AFFORDABILITY FOR SMALL BUSINESSES, YOU WILL BE DOING A GRAVE DISSERVICE TO AMERICAN PRIVATE ENTERPRISE AND ALL SMALL "MOM AND POP" AND FAMILY-OWNED BUSINESSES IN YOUR STATE.

IF CONGRESS SHOULD MANDATE A MINIMUM LEVEL OF HEALTH INSURANCE COVERAGE, I WOULD LIKE TO OFFER SOME ALTERNATIVES FOR YOUR CONSIDERATION:

1. IF PASSED, MINIMUM OR CATASTROPHIC HEALTH CARE LEGISLATION SHOULD BE MANDATED FOR EVERYONE, INCLUDING TAX-EXEMPT NONPROFIT ENTITIES, LARGE EMPLOYERS, AND STATE AND MUNICIPAL GOVERNMENTS.

2. MANDATED COVERAGE SHOULD BE DELIVERED THROUGH WELL-RUN, PROVEN AND EFFICIENT MANAGED CARE PLANS, SUCH AS HMOs, AT THE LOCAL AND REGIONAL LEVEL. PRIVATE SECTOR GROUPS WOULD BE ENCOURAGED TO WORK WITHIN THE SYSTEM TO PROVIDE A GOOD MIX OF QUALITY AND COST-EFFECTIVE HEALTH CARE.

3. SMALL BUSINESSES SHOULD BE GIVEN INCENTIVES TO OFFER HEALTH COVERAGE. CONGRESS SHOULD PROVIDE TAX CREDITS TO BUSINESSES THAT DO COMPLY WITH MINIMUM HEALTH COVERAGE LAWS. THIS TAX CREDIT WOULD ENSURE THAT MANDATED HEALTH COSTS WOULD NOT IMPOSE AN ADDITIONAL BURDEN ON SMALL FIRMS IN THEIR FIRST FEW YEARS, A TIME WHEN THEY ARE MOST LIKELY TO FAIL.

4. CONGRESS SHOULD GUARANTEE THAT MEDICAL EXAMINATIONS WILL NOT BE REQUIRED OF PEOPLE SEEKING HEALTH INSURANCE. THE INSURANCE INDUSTRY'S PRACTICE OF OFFERING AFFORDABLE PREMIUMS TO ONLY THE BEST RISKS (CREAM SKIMMING) IS RESPONSIBLE FOR PART OF THE HEALTH INSURANCE CRISIS WE ARE FACING TODAY.

5. THE SELF-EMPLOYED SHOULD BE ALLOWED TO DEDUCT THE FULL AMOUNT OF THEIR HEALTH INSURANCE PREMIUMS. FOR THE FIRST TIME, THE TAX REFORM ACT OF 1986 ALLOWS THEM TO DEDUCT 25 PERCENT.

6. DEDUCTIBLES AND LARGE CO-PAYMENTS ARE ROADBLOCKS TO HEALTH CARE AND, THEREFORE, SHOULD BE DISCOURAGED. MANAGED CARE WITH NOMINAL CO-PAYMENTS SERVE AS AN INCENTIVE FOR COST-EFFICIENT

HEALTH CARE UTILIZATION AND SHOULD BE INCORPORATED IN THE PLANS.

7. THERE SHOULD BE NO LIMIT ON THE NUMBER OF PLANS MADE AVAILABLE TO EMPLOYEES. GREATER CHOICE MEANS GREATER COMPETITION AND BETTER QUALITY AT A LOWER COST.

8. COST CONTAINMENT PROGRAMS NEED TO BE BEEFED UP. SEVENTY PERCENT OF SBSB MEMBERS RESPONDING TO OUR ANNUAL SURVEY SUPPORT INCREASED GOVERNMENT REGULATIONS TO CONTROL HOSPITAL COSTS AND HEALTH INSURANCE PREMIUMS. THESE ARE THE VERY PEOPLE WHO TRADITIONALLY OPPOSE ANY FORM OF MANDATED BENEFITS. THIS REFLECTS THEIR FRUSTRATION WITH THE HEALTH INSURANCE SYSTEM AS IT EXISTS TODAY.

AN ALTERNATIVE WOULD BE TO EXAMINE THE POSITIVE ASPECTS OF THE CATASTROPHIC HEALTH CARE PROPOSALS OF PRESIDENT REAGAN AND DOCTOR BOWEN. PERHAPS THE GOVERNMENT SHOULD CONSIDER EXPANDING CATASTROPHIC COVERAGE TO INCLUDE THE GENERAL POPULATION AND TO BE PAID FOR OUT OF GENERAL REVENUES. THE GOVERNMENT'S ROLE SHOULD BE TO ENSURE ACCESS, AFFORDABILITY AND QUALITY. ONE MECHANISM THAT COULD BE EMPLOYED BY THE GOVERNMENT TO ASSURE THIS WOULD BE TO REVITALIZE THE HEALTH SYSTEMS AGENCIES (HSAs) OR SOMETHING COMPARABLE.

THERE IS ANOTHER SERIOUS PROBLEM FACING SMALL BUSINESS IN AMERICA TODAY. THAT PROBLEM IS THE BIG BUSINESS ATTEMPT TO DECREASE THEIR HMO HEALTH INSURANCE PREMIUMS AND INCREASE HMO PREMIUMS FOR SMALL BUSINESS.

BIG BUSINESS ACTING THROUGH THEIR AGENTS, THE WASHINGTON

BUSINESS GROUP ON HEALTH, HAVE PRESSURED HCFA, THE HEALTH CARE FINANCING ADMINISTRATION OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO PROPOSE THE REPEAL OF EXISTING EQUAL CONTRIBUTION REGULATIONS IN SECTION 110.808 OF THE HMO ACT. THE CHANGES ARE UNDER CONSIDERATION BY HCFA NOW.

UNDER THIS PROPOSAL, EMPLOYERS WOULD NO LONGER BE REQUIRED TO CONTRIBUTE THE SAME PER-EMPLOYEE AMOUNT TO FEDERALLY QUALIFIED HMOs AS THEY CONTRIBUTE TO THE MORE TRADITIONAL HEALTH BENEFIT PLANS THEY PROVIDE.

BIG BUSINESS WOULD THEN BE ABLE TO DECREASE THEIR CONTRIBUTIONS AND SHIFT THE COST, THUS INCREASING THE HMOs' PREMIUMS TO SMALL BUSINESS. INCREASED HMO PREMIUMS WOULD ACT AS A DISINCENTIVE TO JOIN AN HMO PLAN, AFFECT GUARANTEED ACCESS TO HMOs AND REDUCE COMPETITION IN THE HEALTH CARE MARKET.

THIS IS A BIG BUSINESS PROPOSAL AND IS BAD PUBLIC POLICY THAT IS INCONSISTENT WITH THE INTENT OF THE U.S. CONGRESS WHEN IT PASSED THE HMO ACT.

THE POLITICAL ATMOSPHERE DURING THE LAST SIX YEARS HAS FAVORED BIG BUSINESS. THE 100th CONGRESS NOW HAS THE OPPORTUNITY TO HELP SMALL BUSINESS. MANY OF THE ISSUES WE HAVE DISCUSSED HERE TODAY ARE PERCEIVED AS ANTI-SMALL BUSINESS. CONGRESS NEEDS TO TAKE A CLOSER LOOK AT THE IMPACT THESE PROPOSALS HAVE ON AMERICA'S ENTREPRENEURS. THIS COMMITTEE CAN PLAY A MAJOR ROLE IN ENSURING THAT AMERICA'S SMALL COMPANIES GET THE FAIR TREATMENT THEY DESERVE. THANK YOU.